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ABSTRACT

A national mental health continuing education program for personnel employed in long-term care facilities was developed by the National Institute of Mental Health's Continuing Education Branch. The immediate goal was to demonstrate linkage between mental health, continuing education, and long-term care resources to increase the knowledge and skills of caregivers, based on the assumption that the training would improve the psychosocial aspects of caregiving. The program strategy included involvement of identified leaders in the field, development of demonstration-model-training programs, and strengthening regional office capabilities. This report details demonstration models at Adelphi University School of Nursing and Social Work, Hofstra University School of Education, Massachusetts Mental Health Center and the Boston University School of Social Work; North Texas State University; University of Southern California; and Iowa Lakes Community College. (LBH)

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MENTAL HEALTH CONTINUING EDUCATION PROGRAMS FOR LONG-TERM CARE PROVIDERS

National Institute of Mental Health

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Preface

In some civilizations, the elderly are venerated and occupy positions of power. Their opinions are courted and respected by young people, who look forward to becoming old. In other civilizations, they fare less well.

In the early years of this country, the only recourse open to the elderly impoverished person was the county "poor" house or farm with its dreary exterior and within an even more drab and dull existence. For the most part, however, families were expected to care for their own aged with only marginal assistance from the Government.

In the past generation, the number of elderly has accelerated as the medical profession has made great strides in the improvement of care, and the aging process is better understood. The capacity of families to care for them has decreased. With the disappearance of the extended family, many older persons are finding their families do not have the inclination, the physical space, nor the economic means to care for them.

Instead of staying with relatives as in former years, they are being provided for in many types of institutions, such as hospitals, mental institutions, nursing homes, retirement residences, convalescent homes, and other types of facilities. Most of these facilities are proprietary, and the type of care given the elderly ranges from excellent to extremely poor. Many of the best long-term care facilities offer adequate food, quality medical care, clean beds, but there is little in the environment to stimulate or enrich the life of these elderly occupants.

Far too often, the elderly citizen today is faced with almost as dismal an existence as his counterpart faced in the county poor house of bygone years.

The Government does have a commitment to improve the quality of care which these elderly citizens receive. Aside from purely humanitarian reasons, many of these facilities receive financial support from the Medicaid and Medicare programs. The appropriate agencies of the Government have a continued obligation to see that these elderly people are given the best care which can be obtained.

The staff of the Nursing Home Improvement Program, Continuing Education Branch, Division of Manpower and Training Programs, National Institute of Mental Health, has been especially concerned about the provision of adequate psychosocial (mental health) care.

In a programmatic effort to improve the quality of life in these facilities, a series of projects to demonstrate models of linkages among long-term care facilities, mental health service agencies, and continuing education programs were designed. The training program directors obtained the commitment of top administrators to initiate the training programs. By this method, it was hoped that they would recognize that the continuing education program would not only enable them to cope with the problems presented by their residents, but would also encourage the administrators to treat each resident as an adult, with both psychosocial needs to be fulfilled and strengths to be maintained and developed.

Training methods were purposefully designed to include a mix of experiences. These methods included lectures and feedback, panels, films, experiential exercises, demonstrations, role playing, small group discussions, and problem-solving exercises. These experiences were designed to increase the appreciation of the human aspects of caring as related to the on-the-job performance of employees of long-term care facilities.

We anticipate that top level administrators will continue this type of training program for their staff. If any long-term improvement of patient care is to be had, each new employee must be inculcated with the importance of observing the psychosocial aspects of caring for his charges. Inservice training and continuing education offerings may also be a motivating factor to staff in long-term care facilities which will reduce the high turnover rate among them, especially those persons occupying low-skilled jobs.

Of the four projects described in the publication (an interim report is included in the appendix of a fifth project, still to be completed) every effort was made to provide a varied, geographically diverse training effort which would have far reaching effects on the target population. I hope through these reports, guidance and technical assistance will be provided to persons and groups developing similar training programs on the psychosocial aspects of long-term care.

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Introduction

The Continuing Education Branch, Division of Manpower and Training Programs, National Institute of Mental Health (NIMH), was given the responsibility in 1971 to develop a national mental health continuing education program for personnel employed in long-term care facilities.

This national program is the outcome of a "Plan of Action" formulated by the immediately previous national administration to upgrade the quality of care provided in the Nation's nursing homes.

The Continuing Education Branch staff was aware of the vast amount of experience and resources available in and to the Nation; the task was to effectively link these resources to meet training needs; the immediate goal was to demonstrate linkage between mental health, continuing education and long-term care resources to increase the knowledge and skills of caregivers based on the assumption that the training in turn would improve the psychosocial aspects of caregiving, thus improving the quality of life for residents of long-term care facilities.

Program Development Strategy

Three major areas of program development strategy were initially identified and coordinated in the Continuing Education Branch. These areas were (a) involvement of identified leaders in the field, (b) development of demonstration model training programs, and (c) strengthening regional office capabilities.

Involvement of Identified Leaders in the Field (Gerontological Society contract)

This aspect was implemented principally in cooperation with the National Gerontological Society under an 18-month developmental contract. The first step taken was to hold a national conference to bring key leaders from the theoretical and applied sectors of gerontology, mental health, and nursing home administration together for the purposes: of

- developing priorities for the personnel to be trained;
- identifying the mental health content that is appropriate for inclusion in such training programs;
- analyzing the ways in which the projected content could best be translated into educational models and finally;
- identifying potential organizations or groups of organizations to carry out the program.

Development of Demonstration Model Training Programs

Contracts were negotiated in fiscal year 1972 with different organizations to demonstrate various models of linkage between long-term care facilities, mental health agencies, and continuing education programs.

Adult education guiding principles on which the Continuing Education Branch bases its training endeavors were used as guidelines in establishing the criteria for the selection of the demonstration contracts. They are:

1. While specific training activities may be short-term, long-range

effectiveness depends on an ongoing program of continuing education-staff development in any health services delivery system;

2. Administrative sanction and support of such programs is essential;

3. Training programs aimed at skill-building and attitude-influencing must involve all administrative levels and categories of personnel if they are to be effective; and those receiving training must participate actively in the entire education process-planning, learning and evaluation;

4. Training program content must be directly related to the work situation if it is to be relevant to the trainees; and

5. There are definable special needs of the mentally impaired person, over and above the mental health needs shared by all residents of long-term care facilities, for which mental health specialists have a particular concern. Continuing education is an effective tool in more closely articulating the mental health service delivery system with the long-term care delivery system.

An additional demonstration project added in fiscal year 1973 filled a gap which was identified in the "model system," that being the role which community colleges may play, particularly in the continuing education of paraprofessional personnel. Special attention was also given to the mental health aspects involved in relocating patients-residents from an "old" nursing home to a "new" nursing home.

The next step in this element of the mental health strategy is to provide feedback of knowledge which had been gained in the demonstration projects. Several persons who participated in the demonstration projects presented papers at national and regional conferences, and two articles have been published in professional journals as a result of knowledge gained from this venture. Coverage has been given by various local communciation media to several of these projects.

The project directors met with staff of the Continuing Education Branch on three occasions to share information and suggest methods of disseminating project results.

Strengthening Regional Office Capability

At the inception of the Nursing Home Improvement Program, NIMH was allocated new positions in the 10 regional offices. During 1973, regional consultants identified and assessed learning needs and the training capabilities within their respective States and regions. Consultants provided technical assistance to State and community agencies. They have implemented training activities at the regional, State and local levels, providing consultation services and issuing contracts to provide financial assistance as appropriate. The regional consultants were responsive to State and local needs through the following activities:

- Mental Health Program Development Conferences
- Support of pilot training programs in a given locality or institution
- Training long-term care personnel who can in turn become trainers in their own institutions
- Provide specialized mental health training for State level or local agency consultants whose functions bring them into contact with long-term care facilities
- Provide training for mental health specialists in gerontology, long-term care, or both, to enable them to be of service to long-term care facilities in strengthening the mental health aspects of care.

Increased attention is now being given to involvement of State mental health agencies in direct training activities for long-term care personnel. This involvement of State mental health agencies becomes particularly important as State mental hospitals increase their utilization of nursing homes and related long-term care facilities as community based placement centers for discharged patients. It is increasingly apparent that NIMH has a key role to play in strengthening the linkage between psychiatric treatment facilities, especially State hospitals and nursing homes to: facilities.

1. Increase the capability of nursing homes to receive and adequately meet the needs of mentally ill persons, and
2. Improve the referral mechanisms between these two types of facilities.

The demonstration models described in this publication used the continuing education model to teach mental health concepts to people working in long-term care facilities. The projects demonstrated that improved patient care does occur as a result of training personnel working in these facilities and that resident patients are provided a better quality of life during their residency period in such facilities.

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I. Adelphi University, School of Nursing and Social Work

Mental Health in Nursing Homes Training Project,
June 27, 1972—June 26, 1974

Need for Training Program

The number of persons over 65 in institutions is rising at a rapid rate as population patterns change. For the most part elderly persons are crowded into both proprietary and public nursing homes, with proportionately fewer hospitalized in State Department of Mental Hygiene facilities. The increasing numbers of aged persons in institutions, coupled with the shifts caused by overcrowded facilities, have added a stressful experience for the aged and have affected the nature and quality of their care.

In order that persons living in long-term care facilities can maintain and retain appropriate levels of healthy functioning, they must be approached as individual persons and their problems dealt with accordingly. These residents include the mentally impaired persons for whom practitioners need to assume the role of patient advocate, as well as the alert ambulatory resident whose needs go beyond physical security, watching television, and busy work activities.

There is sufficient evidence that the delivery of health care is inadequate. This evidence includes absenteeism, duplication and fragmentation of services, and employee turnover, all of which disrupt the system and lead to patient dissatisfaction. One needs little experience in a long-term care setting to become aware that, although residents live together, they generally have little meaningful contact. This isolation is not surprising when one considers that many people live a lifetime without experiencing tenderness, closeness, and intimacy.

Because the professional staff generally have been largely educated in cognitive learning at the expense of their affective function, they are often unable to identify their feeling states, whether negative or positive. Many caretakers experience anger, frustration, and disappointment toward themselves, patients, staff, and administrators, without an avenue for identifying or expressing these feelings. These emotions are either turned inward, acted out, or displaced with behavior which blocks their ability to solve problems effectively. Caretakers also need to realize that (a) by not being in touch with their own feelings or (b) because of lack of knowledge about the aging process or failure to apply the knowledge they do have, they inadvertently increase the patient's dependency, psychosocial decline, and physical impairment.[1]

The need for a mental health continuing education training program in long-term care arises from many sources: (a) the increasing number of persons over 65 in institutions, (b) society's attitude toward them, (c) the human dilemma of caretakers who are low on the status and economic ladder and have little voice or decision-making power, (d) failure to recognize that ideological issues underlie conflict in agencies or organizations, and that (e) most nursing homes do not have inservice training programs.

Theoretical Base

Having identified the problems and needs for mental health training, it was necessary to develop a working definition of mental health and a humanistic approach to facilitate change. Mental health practitioners and consultants suggested careful attention to the therapeutic community model, at least to explore the social system of the long-term care institution, and at best to bring about positive change.

Much has been written about the therapeutic community in psychiatric institutions and of the utilization of the therapeutic community model in long-term care institutions.[2–3] Concomitantly, mental health has been written about prolifically and defined in a variety of ways. This ambiguity suggests that mental health does not mean the same thing to all people; it is difficult to conceptualize and more difficult to put into a few words.

For the purposes of this training program, one needs to associate mental health with three words: mastery, fulfillment, and people. For an individual person to be mentally healthy, he or she needs to have: (a) a sense of mastery over what he or she is doing, thinking, and feeling; (b) a sense of being fulfilled or satisfied with what he or she is doing, thinking, and feeling; and (c) meaningful contact with people.

We all know persons who are dissatisfied with their accomplishments; we also know those who master or accomplish their goal and are satisfied but are unable to relate to other persons in a meaningful way. Therefore, neither of these persons would be considered by our definition to be mentally healthy. With this description of the three components necessary for mental health, one understands better the need for, and the benefit of, meaningful contact in a therapeutic community in long-term care institutions, not only to residents and their families, but also to all those who work with the aged and disabled.

Therefore, an important assumption underlying the didactic and experiential presentation in this training project is that it is necessary to change constructively the change agents themselves. This approach requires sensitivity to the role of emotions in influencing the process of decision-making as a cognitive understanding of systems.

Following are some facts used and taught in understanding organizational systems:

Healthy systems change continuously. There is, however, some value in habits and traditions which yield stability and permanence to institutions.

In large organizations, the multiplicity of subunits with specific roles inevitably leads to a more formal definition of structure and function. This formal structure in turn gives us the chain of command, and the power structure, as well as the informal power lines.

Organizational ideology determines how well (a) the organization's interest and the people's interest fit, and (b) how well the organization deals with the internal environment and the outside community.

There is usually a failure to recognize the ideological issues that underlie organizational conflict. Often the problem that is presented is not the real problem. If change is indicated it ought to be planned, taking into consideration that change always causes anxiety.

Conflicts exist in organizations. By dealing with conflict openly, one finds the way to manage it in the service of both the institution and its members; i.e., residents, staff, and administration. Hidden conflict is destructive and erodes the institution.

Program Objectives

This training program provided participants with the opportunity to: (a) become aware of their attitudes toward themselves and toward older persons, (b) develop authentic relationships, (c) deal openly with conflict, and (d) organize and lead groups of residents.

It was designed for all personnel in nursing homes and extended care facilities (now called skilled nursing facilities, regardless of their discipline, role, or function). Three members of each agency were encouraged to attend together in order for them to initiate and help each other maintain the program's objectives. Teams from different facilities varied in their professional composition, but the total group included administrators, nursing supervisors, and inservice educators, social workers or social work aides, occupational, physical, and recreational therapists, and their corresponding aides, head and staff nurses, registered and practical nurses, and nurses aides.

We hoped that participants of this training program in working with groups of residents would help them become more expressive, increase their interactions, reexperience closeness, and increase positive group feelings. These behavioral changes should enable the resident to come to terms with himself, i.e., with his strengths and limitations, with his fears and longings, with his anger and his joy. At this stage, participants would be able to develop programs related to the resident's real life situations.

Specific objectives. Specific program objectives were to help participants:

1. Increase their knowledge of the psycho-social-physiological process of aging with emphasis on how the aged perceive themselves and their problems

2. Increase interpersonal competence enabling them to establish and maintain meaningful contact with residents and staff

a. Understand

- the way one sends or responds to messages
- different lifestyles and value systems
- how feelings influence behavior.

b. Develop skill in:

- listening
- sharing emotional reactions to planned or spontaneous behavior
- practicing communicating one's feelings and ideas in helpful ways.

3. Increase ability to assess physiological, psychological, and sociological needs
4. Become skilled in detecting and preventing the maladaptive patterns of the institutionalized aged
5. Develop an awareness of the special needs of those residents presenting problems in institutions and to provide skilled intervention to maintain optimal functioning
6. Increase their knowledge and utilization of available internal and external resources
7. Develop group leadership skills in:

- sensitivity to group process and dynamics
- techniques for group leaders

To achieve the program's goal, the training program was publicized in the Long Island newsletter of the New York State Nurses Association, and meetings were arranged with an executive of the Nassau County Mental Health Board, with representatives of the Older American Volunteer Committee, groups of nursing home administrators, nursing personnel, and recreational therapists.

Community Steering Council

These efforts culminated in a large Community Steering Council. The Community Steering Council met once each year. The council represented the community relevant to this particular program and included representatives of concerned governmental and voluntary mental health agencies, voluntary and proprietary nursing homes. several faculty members of the training program, and older persons residing in nursing homes. Although the overall task of this council was to examine ways to continue the linkages among the mental health programs, continuing education and nursing homes, an immediate task of these council meetings was to help publicize and recruit those teams of trainees who would fulfill the aims of the program.

The Project Director

For 4 months, the project director was involved in planning and organizing the following: selecting and training the members of the faculty, developing the curriculum content and methodology of the courses, planning publicity projects, and collaborating with the Bureau of Educational Evaluation of Hofstra University.

The Trainers and the Process of Becoming Training Teams

In the courses which were planned, taught, and attended by interdisciplinary teams, an important focus was on method. This means that how a course or workshop was planned, taught, and attended was as important as what was planned and taught.

This training project was a branch of earlier programs of the Schools of Nursing and Social Work Continuing Education programing. Many faculty members were selected because they had participated in previous Adelphi University Continuing Education Human Relations Training Laboratories. They had a commitment to a continued, enriched understanding of self, and others—whether professional or personal—which enabled them to work effectively. A core group of trainers with special knowledge and talent for experiential learning methods emerged as the project progressed, and they in turn were able to transmit acquired skills to others within the training program as well as within their own organizations. The training, thus, was structured on a deep conviction that those who learn to be in touch with themselves and with others over time are able to live more effectively and assist others in the process.

The courses included sharing of thoughts and feelings and continued review and discussion of shared experiences. The theoretical aspects of the curriculum in the form of lectures and pertinent literature were integrated in every aspect of the experiential design. This cognitive dimension was tested, and trainees in every section demonstrated a statistically significant increase in knowledge (see page 10). The trainers expected trainees to develop insight into those behaviors which enhance (a) linkage between people and agencies for a humanistic problem-solving approach and (b) creative change toward helping older persons experience living more meaningfully.

Faculty teams were developed in terms of their own ability to communicate openly and plan and work significantly together as people. Taking into consideration their availability and the geographic location of courses, team members began to work in succeeding courses and succeeding sections. This plan supplied continuity and strengthened the curriculum as members of the faculty developed creative teaching strategies and used training time more effectively. To provide continuity, one social worker who was employed solely by continuing education, taught in 13 courses during the 2-year period, and one clinical nurse specialist taught in seven.

Recruitment and Enrollment

A six-page brochure publicizing the program, including the schedule of courses for the year, was mailed to every director of nursing and to every nursing home administrator on Long Island 5 weeks before the beginning of each training year. Before the start of the second year of training, a news release on the program and a picture of the director appeared in *Newsday*, a major Long Island newspaper, whose circulation is among the top 10 in the nation.

All personnel in nursing homes and extended care facilities were invited to participate as members of an agency team. A minimum of three trainees was encouraged to attend together as a team to implement the program's objectives in their own facility. For the most part, teams of trainees did enroll and the expectation that two of each three trainees would continue into the course on group work did materialize. Exceptions were made at the discretion of the director.

Knowing that change in any institution requires the involvement and commitment of the top administrator, the nursing home administrator was encouraged to become a team member. (Nursing home administrators were recruited as team members with ease, since the training program had been approved by the Board of Examiners of the Nursing Home Administration of the New York State Department of Health for 104 continuing education credits. One hundred credits are required every 2 years for nursing home administrators' relicensure.) Teams varied in member's discipline, role and function, but in each training section, there were representatives from administration, nursing, social work, recreation.

In the 2-year period, 17 courses were given in which 16 different faculty members participated. A total of 208 trainees were given training which represented 47 nursing homes with more than 10,000 residents. About one-half of the trainees were nurses. One-fifth of the trainees were nursing home administrators and the remaining trainees included almost all conceivable nonresident adults who could be found working in a home.

Training Methods and Rationale

The training included lectures, discussion, and structured experiences. The structured experiences grew out of a theoretical framework which was to guide the practitioner in initiating and maintaining meaningful contact with residents, family members, staff, and the community. It was essential for practitioners to learn how the aged person saw himself and his problems and how he or she could be helped to deal with what was perceived, how he interpreted his perceptions, and the way in which he responded to them.

All groups were experientially based, and this training was carried out largely in small groups with a mixture of trainees in each small group. These group experiences helped personnel to deal with interpersonal and group living problems with depressed, regressed, confused residents and their families. In addition, these experiences helped to explore and resolve intergroup conflict caused by the racial, ethnic, and socioeconomic composition of staff and patients.

The training program model: a sequence of courses and onsite consultation. The training program consisted of a sequence of three courses repeated twice, followed by onsite consultation. In addition, the first course was repeated two times and the second course one additional time. Some of the trainees who enrolled in these limited sections continued the program in the second year. At the request of trainees who completed the series in the first year and those who wanted to continue their training, a fourth course, "Training Group Leaders" was added.

Description of Courses

The training program consisted of the following courses: Mental Health and Gerontological Practice in Nursing Homes (1 day a week for 8 weeks); Gro[illegible] Process and Group

Dynamics (one half-day for 8 weeks); Training Group Leaders (one-half day for 8 weeks) and in the second year "Supervision of Leaders" was added. Four interdisciplinary faculty member teams taught in the first course in each of the four sections in the project's training period.

A month prior to the beginning of the first section, a 1-day session for training faculty (trainers) was held. Twelve members of the selected faculty pool and three members of the evaluating team participated in the training session. The purpose of this training session was twofold: (a) to provide an opportunity for trainers to begin to work as four member teams and (b) to involve the trainers in the construction of the evaluation tools. The process of constructing a cognitive tool by trainers with tutelage by the evaluating team facilitated value clarification, team cohesiveness, and a commitment to the goals of the project. An interdisciplinary faculty from the university and from mental health and nursing home facilities was involved in planning, training, and course feedback mechanisms, as well as in providing followup onsite consultation.

Course Content

In the first course, *Mental Health and Gerontological Practice in Nursing Homes*, the trainee was offered an opportunity to grasp the relationship among the sociological, psychological, and physiological phenomena of aging. Emphasis was placed on maintaining optimal functioning of residents through a guided theoretical and practical assessment of, and intervention into, the psychosocial, physiological, and environmental aspects of aging. The intervention included effective utilization of internal and external resources. Structured exercises were utilized to promote clinical and interpersonal competence.

The second course, *Group Process and Group Dynamics* (one-half day for 8 weeks) was designed to increase the trainee's effectiveness both as a group member and as a group leader. Learning was achieved through the examination of the actual experience of the group. Trainees were to have an opportunity to: (a) increase awareness of their feeling experiences and of their reactions to and impact on others, (b) become more effective in expressing what is going on within themselves, (c) become acquainted with processes common to all kinds of groups, (d) experience those forces which influence group behavior, and (e) practice intervention.

The third course, *Training Group Leaders*, was a continuation of Group Process and Group Dynamics (one-half day for 8 weeks). Trainees who currently were not leading a group were to select a group to work with on a weekly basis. The group could be comprised of residents, family, staff, or a community group related to the institution. The purpose of the group was decided by the group leader or the group members. In this experiential group course, the trainee's group work was discussed and the actual experience of the group was examined.

The fourth course, *Supervision of Group Leaders* (one-half day for 8 weeks), was designed to meet the needs of trainees who were leading groups. Some of these trainees were being called upon to supervise other personnel leading groups. Therefore, this seminar provided an opportunity for trainees to develop their own leadership skills and to develop their capacity to train and supervise others. Didactic content was supplemented by experiential learning so that the impact of the learning would be emotional as well as cognitive.

This training course was offered four times during the training period of 1 year at various long-term care institutions in different locations on Long Island. By giving the courses at different locations, nursing home personnel who lived and worked as far as 90 miles from the University were able to participate.

Experiential Learning

Consideration was given in the experiential design of the courses to make it possible for each participant to become more effective in what he or she was doing and more proficient in understanding the why as well as the how of human behavior. The training program content focused on the experience of the resident to initiate and maintain meaningful contact. Trainees became sensitive to the emotional makeup of the older person, that is, what and how he perceived, interpreted, and responded when talked to about himself and his experiences. The trainees also read personal accounts of how older persons see themselves and their life situation.

Techniques Used

Techniques were used that simulated the experiences of the older person. Examples of simulation equipment used were as follows: by means of a specialized tape recorder (A), which provided delayed feedback of speech, and a pair of goggles (B), which rotate the axis of the visual field, trainees were able to experience a simulated view of neuromuscular disability. When the tape recorder delayed the trainee's speech sounds a fraction of a second, it caused the trainee to retard his rate of speech, increase his pitch and loudness, to falter his vocal rhythm, and to frequently misarticulate. This speech pattern is similar to that of a person who is hemiplegic. When the trainee wore the goggles, which contained an arrangement of mirrors that rotate the entire visual field 5° to 20° to the left or right, he walked slowly with hesitation. He also had difficulty in maintaining his balance and would grasp the wall if it was within reach.

A record (C), "Getting Through," a guide to better understanding of the hard of hearing was used. This audio exercise enabled trainees to experience the sensation of hearing when certain speech frequencies are not heard. The record offered an "Unfair Hearing Test" and suggested a few simple rules for making oneself easier to understand when conversing with a hard-of-hearing person.

These exercises created increased sensitivity and more constructive attitudes toward the disabled older person. The demonstration helped to impart certain facts about the nature of disability and how this type of disability produced the illusion that the subject was suddenly confused, stupid, or paranoid. Trainees were to become aware of residents' behavioral changes caused by sensory disturbances and neurological and neuromuscular dysfunctions. As anticipated, these teaching tools engendered many thoughts and feelings on the part of trainees.

The trainees related what they experienced to residents whom they knew and cared about. Others spoke about their process of aging and of their feelings of loneliness. Some of the lessons learned from these exercises were: (a) individual persons differ in their response to imposed sensory distortions, (b) a perceptual disability affects the total person and his effect on others, (c) handicapped persons have an inordinate need for personal contact with someone who is aware of their experience, and (d) recovery of normal function is facilitated on the part of the trainee by active movement.[3]

Group Training Important

Small groups, which included trainees from different occupations, were generally trained together. These group experiences helped participants to deal with interpersonal and group living problems with depressed, regressed, confused patients and their families. In addition, these experiences helped in exploring and resolving intergroup conflict caused by the racial, ethnic, and socioeconomic composition of staff and patients. To accomplish all this, relevant findings were used from sociology, social work, physiology, psychology, psychiatric nursing, group work, and adult education. Participants received a bibliography and a working library of reprints and reports selected for relevance and clarity. Participants also purchased several paperback books which were required reading.[4,5]

Results

This model of mental health continuing education which included structured and unstructured experiences facilitated personal growth and the transfer of learning to the residents of the long-term care setting. An important goal had been to effect change in the trainee's behavior at work. The ripple effect built into the program also helped change the behavior of personnel who were not in the training program. Ultimately, all those who came into contact with residents, including relatives, became part of the therapeutic community and helped rehumanize the lives of residents. The training staff reinforced the idea that residents were a source of meaningful human contact to each other when the structure, climate, and personnel foster "caring" relatedness.

A poignant example was reported to the project staff by a Director of Nursing of a private nursing home. While a participant in the training project, a nurses aide encouraged residents to form a group. They met twice a week for several months at a regularly scheduled time during the day. One evening, one of the members of the group, feeling very ill, asked his group to come to his room. As they were sitting in a small circle, he told them that he was dying, he closed his eyes, dropped his head, and quietly died. One of the group members summoned help. The remaining group members remained in his room and continued to talk about what had happened. This saddened group of people agreed that when it would be their "time to die" they believed that they could call in their "group" for comfort.

Onsite Consultation

Onsite consultation was encouraged by trainers and project staff at the end of the second year of the program. Lack of knowledge, distortion, and apprehension on the part of trainees regarding consultation existed. Since many of the trainees in the second year were not the administrators, there was also concern about who would initiate the request. The project director mailed a letter to the administrators, and called key people in the agency to explain further the nature of consultation being offered by the project.

These two methods of communication, plus providing opportunity in the training session for trainees' concerns, questions, and comments were helpful. More than 20 agencies were visited for half-day onsite consultation by trainers. Several agencies received a second visit. The nature of the consultation visit ranged from consultation to administrators, to staff who had participated in training and who were leading groups, and to a mixture of administrators and key staff personnel. Some visits combined consultation with several key people and direct human relations training for all personnel who work in a nursing home who may not normally be involved, e.g., business office staff, telephone operators, payroll and transportation workers, dietary, physiotherapy, housekeeping, maintenance, and security personnel.

Trainer consultants wrote a one-page summary report of each visit. Consultants were received enthusiastically, but the reactions of consultants to some of the nursing home settings were less than enthusiastic.

There was general agreement that the onsite mental health consultation was worthwhile. For this kind of consultation, however, to have an impact on sustaining growth in an agency, consultation needed to be on a continuing basis.

Fostering Constructive Change

To foster constructive change in the system, and change in the caretakers, the training program provided participants with the opportunity to: (a) become aware of their attitudes toward themselves and toward older persons, (b) develop authentic relationships, (c) deal openly with conflict, and (d) organize and lead groups of residents. A major thrust of the design of this program was for all participants to lead some group in their agency. The composition of groups included residents, staff, staff and residents, residents and family. Descriptions of some of the groups are as follows:

(1) Six nurses aides met with leader (assistant director of nursing) every Wednesday. The purpose was "to establish communication, permit ventilation of known or unknown problems, problem solving."

(2) Eleven staff members from two different shifts and two different units including the Nursing Home Administrator met weekly with the leader (nurses aide) to "examine what's going on with us." This group has been successful in opening up communication vertically and horizontally. They influenced the administrator to reverse his decision when he arbitrarily changed the prizes for bingo games from money (small change) to small gifts.

(3) Eight residents and three staff members met weekly with the leader (Director of Activities) "to get to know each other better for the purpose of more understanding of how residents and staff feel and an opportunity to discuss and express these feelings."

(4) Eight ambulatory residents and four residents in wheelchairs met weekly with a leader (Assistant Nursing Home Administrator) to play Yiddish records, speak in Yiddish, reminisce about Jewish traditions and customs.

(5) A Nursing Home Administrator met weekly with residents who were being transferred from a nursing home to an extended care facility. They also included some residents who were not going but who were attached to those leaving.

(6) Six residents met weekly with a leader (staff nurse) who was an activity director for remotivation activities.

(7) Three residents and several family members met with a social worker to "focus on their thoughts and feelings."

Participants also worked with groups of residents to help them become more expressive, to increase their interactions, reexperience closeness, and to help them increase their positive group feelings. These behavioral changes enabled the resident to come to terms with himself, i.e., with his strengths and limitations, with his fears and longings, with his anger and with his joy. Participants were able to develop a program related to the resident's real life situation as suggested in the literature.[6–8]

The Training Project as a Demonstration Model

Evidence continues to confirm that this demonstration mental health continuing education training project did indeed become a model for other long-term care mental health training programs in other geographic areas in many replicable ways. Facets of the design are being repeated at the Continuing Education Department at Adelphi University and also in the HEW Regional training site at Burke Rehabilitation Center, White Plains, N. Y.

Recommendations

In addition to the direct training of personnel teams in long-term care settings, the major aspects of this project can be adapted for the following purposes: (a) training trainers, (b) training inservice educators, and (c) training all personnel whose work brings them into contact with older persons, i.e., in community settings, housing projects, general hospitals, and outpatient clinics.

An important recommendation is the need for followup in some planned fashion, either (a) onsite consultation on an ongoing basis, preferably beginning onsite visits during the training phase, (b) periodic problem-solving clinics, (c) seminars for specific selected purposes or a mini-workshop.

HOFSTRA UNIVERSITY SCHOOL OF EDUCATION, BUREAU OF EDUCATIONAL EVALUATION: *Evaluation*, JULY 1, 1971—AUGUST 17, 1974

To determine the efficacy of the Mental Health in Nursing Homes Training Project, an evaluation design was constructed by the Bureau of Education Evaluation of Hofstra University, an agency independent from the project, although members of the evaluation project worked closely with the project director and instructors from Adelphi University. Pierre Woog, Ph. D., an educational psychologist, was director of the evaluation project.

Demographic Data

In 1973, the training project included 32 nursing homes, 128 trainees, and 6,058 nursing home residents distributed over an area of more than 4,000 square miles, with a population greater than 3½ million residents.

The range of possible residents of the nursing homes varied from 16–1,000, with a median of 150 and a total of 6,058. The range of possibly affected residents was 10–83 with a median of 55 and a total of 1,185.

The number of trainees from nursing homes ranged from 1–10 with a median of four.

The number of trainees by job category are given in the following list:

Job category (1973)	*Number of trainees (1973)*
Administrators (includes supervisors, coordinators, directors, assistant directors, and head clerks)	34
Nursing staff (includes nursing directors, head nurses, staff nurses, practical nurses, inservice education nurses, and geriatric nurses)	57
Activities and recreation (includes leaders, recreation aides, recreation directors, and instructors)	13
Social workers (includes mental health therapists, caseworkers, assistants, and social worker designees)	10
Aides and volunteers (includes directors of volunteer nurses aides)	7
Others (includes dietary consultants and housekeeping consultants)	7
Total	128

In 1974, the project included 30 agencies of whom 28 were nursing homes. These 28 nursing homes had more than 4,400 residents of whom 1,155 were the potentially affected population. Of the 28 nursing homes, 21 were included in pre- and postobservations. The other seven were excluded because only one trainee participated from each home.

The size of the nursing homes varied greatly and the range of possible residents was from 21–1,000 with a median of 100 and a total of 4,448. The range of possible affected residents was 10–127, with a median of 50, and a total of 1,155. The number of trainees from agencies ranged from one to nine with a median of two, and a total of 116 trainees participated in the project.

When trainees were compared by job categories for the 2 years, discernible shifts were apparent. The proportion of nurses and paraprofessionals remained somewhat constant, about one-half, although the proportion of administrators decreased from one-fourth to one-tenth, and the proportion of aides and volunteers rose from 5 percent to 15 percent. This shift can be best explained by the fact that one-half of the 23 nursing homes had sent trainees who were administrators; thus, the supply was limited. The shifts in occupation of the trainees in 1974 resulted in a trainee population which had more direct contact with residents while at the same time had hierarchical support from the administrators who had previously taken the training courses.

Examination of the demographic data also suggested that the second year offered two distinct training modes. First, new teams were recruited to begin training with the opportunity to participate in all three basic courses. This expanded base had resulted in a more heterogeneous trainee population as compared with 1973 and a high attrition rate which seemed not to be dominated by an agency decision but rather by individual trainee decisions. Of the 33 dropouts, 21 were en masse from agencies; however, 10 of these 21 came from agencies that were involved in other categories of training. Thus, it would seem that two-thirds of the dropouts were motivated by individual rather than by institutional needs. The pattern that seems to emerge is one of high institutional motivation and less than high participant motivation. The second mode of training was offered for either unfinished training for prior participants (1972–73) or additional training, course four. This mode provided for continuity of training between agencies and the project and remedied some of the inadequacies of the first year in that some agencies could only send teams to the first course because of project time constraints.

Evaluation of Trainees, Residents, and Nursing Homes

The evaluation had two main aspects: How had the project affected trainees both affectively and cognitively? What impact had the trainees had upon their institutions in general and residents in particular? The evaluation design, therefore, included both precognitive and postcognitive attitudinal tests. Impact evaluation included onsite preinterviews and postinterviews of administrators and residents. To assess the effect of the project training upon those directly trained, two formal prestrategies and poststrategies were used; knowledge-cognitive and attitude-affective.

Trainee Evaluation—Knowledge-Cognitive

To assess the cognitive growth of trainees in the area of the elderly a "tailor-made" pretest and posttest were constructed by those who ultimately would be participating in the training with the professional assistance of the evaluation team.

In 1972, the evaluation team, the project staff, and the trainers met for a day to construct the cognitive test. This day was followed by meetings among trainers to generate test items.

The goal for the day was twofold. First, instruction by the evaluation team was needed so that the trainers would understand and be able to apply test construction methodology that would result in the best content validity for the test. Second, the trainees would develop a test blueprint which would reflect their perception of the universe of knowledge to be explored in the project and generate sample items which would represent this universe for testing purposes.

The testing method was constructed so that it would be impossible to "teach for the test." This safeguard was achieved by making sure that trainers only constructed limited segments of the test, the evaluation team edited all items, the evaluation team was in sole possession of the tests, and both a pretest and a posttest were constructed.

The entry point to constructing the tests was a list of area contents-content dimensions which follows:

- Attitudes toward aged
- Physiology of aging
- Social-psychological aspects of aging
- Institutionalization and institutional change techniques
- Filial and spouse relationships—feeling of guilt and dependency
- Community resources
- Sex and aged persons; biological, psychological, and social differences
- Death and dying—family and staff crises; stages of deterioration, institutional patterns
- Economic support systems—Medicare and Medicaid
- Mentally impaired aged and techniques to prevent or alleviate

- Participatory government—decision-making via resident input
- Reality orientation
- Interdisciplinary team: clinical specialist and consultation.

These 13 content dimensions were finally reduced and synthesized into four-by-four dimensions of cognitive processes. Thus, a four-by-four blueprint was constructed and each dimension was weighted as compared with others by the degree to which the group felt it was important.

Once this blueprint was constructed the trainers were grouped by content dimension to generate specific items to accommodate the blueprint cells. This work was continued independently by the groups so that they might make use of available literature within the content dimension.

By the following week all trainer groups sent their items to the evaluation team where they were edited and typed on five-by-eight index cards and also cataloged by cell. From each cell an equivalent number of items were randomly selected to create before and after forms of the test.

Each pretest was given to the four trainee groups at the initial session of the first course. The posttest was given at each closing session of the first course. Split-half reliabilities were computed for each testing. These eight reliability coefficients ranged from .73 to .96 with a median of .88. For all groups, posttest scores were significantly higher than pretest: $P < .05$.

These results supported the hypothesis that significant positive cognitive learning occurred as a result of the training and all groups included in the project did show positive improvement.

The training given in the project brought about desired change, as specified, on the part of the trainees. Although this is commendable, it must be perceived as an evaluation of the "means" rather than the "ends." The important results of the evaluation must be within the context of the "ends"; namely, how were the institutions and the residents of those institutions affected by those trained? What was the measurable "impact" of the project? In the section on impact evaluation, we examined this question and determined the effect the trainees had on the residents.

Trainee Evaluation—Attitudinal

To measure attitudinal change all trainees were given an attitudinal test upon entering the project. Those who went through all courses were administered the same test as a posttesting instrument. Approximately 6 months lapsed between the pretest and the posttest.

The result of this strategy was a limited number of posttest measurements because this test was given only to those trainees who had completed all three courses. This constraint was imposed for three reasons. First, durable attitudinal changes take time. Second, the primary focus of the first course was cognitive while the primary focus of the two subsequent courses was affective. Third, because the same test was used before training and after training, the maximum time between testing was necessary to minimize learning from the pretest. It was hypothesized that attitudes would change positively to a significant degree.

To measure positive change in attitudes toward elderly people in general, trainees were given the "Attitudes Toward Old People Scale."[9] Odd-even reliability data showed reliability indices ranging from .66 to .83.

In using the scale, testees were asked to respond to 34 statements, 17 of which were positively stated and 17 of which were negatively stated. Each statement was of the Likert-type (a scale for giving values for individual reactive attitudes) with responses varying from "strongly disagree" to "strongly agree." Score values per item ranged from one to seven. The higher the total score the less positive the attitude toward the elderly. The lower the total score the more positive the attitude. Scores can range from 34 to 238.

When the results of the tests were examined, they supported the hypothesis that significant positive change in attitude, as measured, would result from training in the program. All tested t values were well over the critical level. It was interesting to note that the correlations between pretestings and posttestings were also significant. These correlations suggested that the increase in positive attitudes was somewhat uniform and offered further evidence of the reliability of the instrument. When one considered the population of the trainees, most of whom were career and professionals in the area of the aged, a significant positive change toward their professional clients was an accomplishment.

Situational Preference Inventory (SPI)

In 1974 another test entitled, "The Situational Preference Inventory"[10] was given to all trainees who had completed the courses to measure changes in interactive styles (this test was not available in 1973). This test was developed by Carl N. Edwards and was designed to assess individual styles of social interaction. The inventory employs a forced-choice format and consists of 22 sets of statements. Each set contains three statements, each representing a different style of social interaction: cooperational, instrumental, or analytic.

Edwards describes the styles as follows:

> "Cooperational interaction is characterized by receptivity to and understanding of the needs of others and resolution of social conflicts through personal sacrifice.
>
> "Instrumental interaction reflects a preference for dealing with situations by structuring them and through close reliance upon lines of authority, similarity of interest, and adherence to tradition and custom.
>
> "Analytic interaction is characteristically represented by a tendency to deal with people and situations through an understanding of situational and interpersonal cues and through exploration of other than existing or normative courses of action."

Score values for each set of statements range from two to zero, two being added to the score of the scale whose item is indicated as most agreed with and zero added to the score of the scale whose item is least agreed with. One is added to the score of the scale whose item is neither most nor least agreed with. The possible scores for each scale range from 0 to 44. The sum of the scores on the three scales was 66. Test-retest reliability data show reliability indices of .735 for the cooperational, .817 for instrumental, and .804 for the analytic styles.

The SPI was administered at the same time as the attitudinal measure to those trainees who completed all training courses within a pretest-posttest design. The same instrument was used for both pretests and posttests.

It was hypothesized that, as a result of training, analytic scores would increase significantly, and instrumental scores would decrease significantly.

Results

Trainees did not seem to become more analytic as measured but did become less instrumental. It is an interesting finding for it would seem that the dynamics of personality that make for change form a dyad of examining perceived value structures and then seeking alternatives. The first component is decreasing one's instrumental social interaction style; the second increasing one's analytic interaction style.

Kogan,[11] when validating "Attitudes Toward Old People" found a high correlation between less positive attitudes toward the aged and anomie as measured by Srole. Anomie is described as a helplessness in the face of powerful social forces which would seem to capture the instrumental style. It would seem that trainees were attempting to break down value perceptions that emasculate but have yet to internalize a repertoire of strategies that help them reexamine or analyze in order to make creative changes.

Evaluation of trainees indicated that there was a significant gain in knowledge, a significantly more positive attitude toward the aged for those that came into training with a less positive attitude, as measured, a significant decrease in instrumental interactive style but as yet a lack of increase in analytic style.

Overall, the project seems to have had a positive effect on trainees and the question was whether these change were manifested in their work locales. It must be stressed that the training of trainees was a means—the ends being beneficial effects in the nursing homes.

Impact Evaluation

To assess the trainees' effect within their nursing home settings, trained observers conducted structured observations and interviews within a pre-post design. These evaluative measures were of two general types: those in which the nursing home environment was examined by use of interviews with administrators and observations of the entire facility and those in which residents were interviewed within the homes.

The instrument selected to evaluate the total environment was a modification of that used by Darrell Slover.[12] In this instrument, 12 constructs were examined because we hypothesized that the higher the score per construct the better the home would be in meeting the physical and psychosocial needs of residents. Modifications were made to accommodate dimensions not originally in the instrument but specifically germane to the project's specified objectives, namely, group functioning and interagency communication for a total of 14 constructs.

Although reliability and validity information was available per construct-dimension, many of the reported indices were deemed less than adequate. For example, reliabilities ranged from .15 to .87. Therefore, the interpretation of the results of the instrument is more valid when one looks at the composite or total score, which is highly reliable. This inadequacy should not be surprising, given the ambitiousness of the instrument. It was hypothesized that nursing homes would have a significantly positive change in their total score as measured by the "Impact Evaluation Instrument of Agencies" (IEI).[13]

Residents were interviewed to determine whether, as a result of the project, there was a significant positive change in their mental status. Mental status was operationally defined as the scores from three well-established measures of mental status: Life Satisfaction Index (LSI)[14] long form, Mental Status Questionnaire (MSQ)[15] short form, and Face-Hand Test.

To include all residents who might be affected by the project and to control for the disparate size of nursing homes, the following procedure was adopted.

A random sample of 10 residents per nursing home was selected to evaluate the project's effectiveness. This number could control for the varying number of residents per home and yet could make random selection possible. Before sampling could begin, however, a population of residents had to be defined. Some of the residents were not functioning at a level at which much intervention was possible nor could they communicate with the interviewers so they were not considered for the project. Also, some nursing homes were so large, with as many as 1,000 residents, that training four or five staff members could not possibly affect such a large number. Thus, it was necessary to delineate a population that could be affected and which was in contact with those persons trained in the project.

All trainees at the first meeting of the initial course were given a form, "Contact Form for Agency Personnel," which asked them to list residents in their agencies according to the following criteria:

1. Those with whom you are in direct contact for at least 10 minutes per week.
2. Those who had a memory deficit, were forgetful and disoriented to time and place but were able to socialize minimally, did have the ability to perform with or without assistance a few daily living activities such as eating, dressing, shaving, or bathing.[14]

These completed forms were collected the following week and constituted the population, 1,185, of which 10 were randomly selected for both pretesting and posttesting for each agency. In addition to the 10 randomly selected residents, an additional five per home were also randomly selected as alternates. Thus, for each home there was a population of possibly affected residents from which pre- and post-independent random selections were made (before and after the testing). This procedure insured that only residents that could be affected by the project were included, that the size of the agencies was controlled, and that by random selection no bias on the part of the agencies could occur.

Once the impact evaluation was designed and instruments were selected, modified, and collated, observers were trained in use of the instruments. Observers were selected who had had previous experience in the field collection of data and were professionals in an area that dealt in human service. All had had previous formal training in interpersonal relations.

After the training was completed which mostly consisted of role-playing techniques, teams of two were formed and given a folder for each nursing home. These folders contained the impact evaluation instrument, the various resident interview forms, and a list of randomly selected residents to be interviewed. Before the teams went to the agencies, the evaluation procedure was explained to the staff of each agency when they were given the "Contact Form for Agency Personnel." Upon arriving at an agency, one observer completed the formal interview section of the impact evaluation instrument while the other completed the formal observation segment. Then both observers cooperated in the resident interviews. This pattern was repeated for all four-course cycles, pretest at the time an agency began participation and had completed the project, and the posttest by a different team of observers.

Because the impact evaluation was conditioned by the specific entry point of an agency's participation in a project, the time between preimpact and postimpact evaluation varied. For the first course cycle, the elapsed time between preimpact and postimpact was 7 months, for the second, 6 months, for the third, 3 months and for the fourth, 2 months. Only for the first two cycles did trainees go through all courses. These two constraints of the project, when added to general deterioration of residents in nursing homes, mitigated against any positive findings.

Agency—Nursing Homes

The 14 dimensions of the Impact Evaluation Instrument (IEI) were as follows:

Resources
Cue richness
Fostering achievement
Fostering dependency
Recognition
Stimulation
Fostering affiliation
Tolerance of deviancy
Warmth
Individualization
Fostering autonomy
Physical attractiveness
Group functioning
Interagency communication

The results show that, overall, there was a significant positive change as measured in the nursing homes, although this change could not be isolated in the dimensions. This inability to measure change is probably because of the impreciseness of each dimension in isolation. The finding does demonstrate that within a short time, with the constraints already mentioned, positive institutional change did occur. This positive change is certainly the major finding of the evaluation report.

A further finding strongly suggested that the positive impact of the program showed tremendous gains when trainees took more courses and had the time to put into practice their new knowledge, skill, and attitude. Furthermore, it suggests that with more time and extended project support the agencies should continue to change in a positive direction.

Residents

A significant increase in residents' mental status was only found for the Face-Hand test; no significant increase was found for either the Mental Status Questionnaire nor the Life Satisfaction Index. There are three possible explanations for this mixed finding, although it should be strongly noted that this is not a negative finding.

First, it could be hypothesized that the measuring instruments were not precise enough to measure the significant positive change that did in fact occur. This lack of validity is possible, but doubtful, for all three instruments have an enviable record of being valid enough to pick up such change; however, they may not have in this project.

The second possible explanation was that not enough time had been allotted to the project to affect this type of change and that given further staff training and time, significant positive change in residents' mental status would result. This explanation is certainly possible.

The third possible explanation may be found in the nature of the population. Two facts emerge. First, the aged population in a nursing home is highly heterogeneous in mental status and highly changeable. Second, general deterioration is a fact, although most difficult to deal with. Simply stated, numerous residents die or are in a state of dying between any time lapse. At the risk of sounding inhumane, it must be said that given these facts, a researcher's task is made more difficult when he hypothesizes positive change through systematic intervention in a well-controlled design within the context of general personal deterioration. Thus, the expectation of significant positive change may be unrealistic. It just may be that the lack of negative findings is in fact positive.

Recommendations

Following the established pattern of cooperation between project staff and evaluation team members, both groups, including observers and trainers, met in October 1973 to discuss both the recommendations made in the evaluation report and the perceptions of the onsite observers. As such, the original evaluation was used not only as a statement as to the efficacy of the project but was further utilized as a planning document for the second year.

What follows, in outline form, is the thrust of the recommendations and the subsequent actions.

Recommendation (1973)	*Action (1974)*
Training	
• Provide trainees with a glossary of terms used in training	• Glossary written and distributed
• Attempt to have all trainees take all courses	• All trainees were offered this opportunity
• Attempt to include medical doctors as trainees	• Only one trainee was a medical doctor
• Come to grips with questions pertaining to risk versus letter of the law	• Not formally evaluated
Nursing Homes	
• Provide onsite consultations	• Twenty nursing homes have had consultants of 1 or 2 half day(s) per nursing home
• Encourage interagency visitations	• Formally adopted as a curricular aspect of the first course
• Encourage short-role function changes within homes	• Not adopted as decided by project staff and trainers
Evaluation Design	
• Increase the number of alternate residents for postinterviews	• Raised from 10 to 15
• Raise the significance level for measuring positive resident change from .05 to at least .10	• Acted upon
• Between preimpact and postimpact evaluation, have a minimum time lapse of 6 months.	• Completed in all cases.

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16. Miller, M., Synthesis of a therapeutic community for the aged ill. **Geriatrics,** 21 : 151–163, August 1966.

LIST OF EQUIPMENT USED

Description	*Address of supplier*
(A) Specialized tape recorder	Lomask Engineering, West Woods Road, Sharon, Conn.
(B) Specialized goggles	Pentagon Device Corporation, 21 Harriet Drive, Syosett, N.Y. 11791.
(C) Record "Getting Through"	1971, Zenith Radio Corporation, 6501 W. Grand Ave. Chicago, Ill. 60635.

II. Massachusetts Mental Health Center and the Boston University School of Social Work, Division of Continuing Education

Nursing Home Education Project, June 26, 1972—September 25, 1973

MASSACHUSETTS MENTAL HEALTH CENTER

Introduction

Nursing homes are institutions where people who are ill and old are placed by their families or other agents in the community. Although they may adjust to life in a nursing home, there is little question that residents would rather live somewhere else. In addition to the implication that life is approaching its limit that living in a nursing home implies, most nursing homes are highly structured environments with little privacy. The staff know everything about the resident, including his background, the number of visitors he has, the type of pills that he takes, and even the time of a bowel movement. Carlson [1] points out that for the aged person, removing the right to make decisions is a form of intellectual deprivation. Thus, although the nursing home may provide the best possible physical care for the individual aged person, the high degree of structure makes for a limited environment for the resident.

Background

Members of the staff of the Geriatric Unit of the Massachusetts Mental Health Center were especially concerned because its consultation services in nursing homes were revealing a definite need for greater understanding of mental health and the psychodynamics of aging. The staff of the unit believed that more social orientation in the medical model so narrowly followed in many of the homes would improve the mental health of the residents.

Clearly, our concern was to disseminate mental health principles throughout each home and from one home to another if better patient care in a more therapeutic milieu was to be achieved effectively. Better patient care could only be carried out by more sensitive and knowledgeable employees and administrators.

Because there are 50 nursing homes with 3,000 beds in the Massachusetts Mental Health Center's catchment area, the staff of the Geriatric Unit gave this project high priority. With more elderly mental patients being discharged by the mental hospitals to nursing homes and with the staff of these nursing homes turning to the staff of the Geriatric Unit for consultations concerning handling and understanding behavioral difficulties, the preventive nature of such an educational approach was especially attractive.

Improved patient care by helping the employee to comprehend the emotional needs of patients was the staff's primary objective, and to achieve this, it was believed that a comprehensive educational program was essential for nursing home employees at all levels. Focusing on their attitudes and increasing their understanding of the aging process, therefore, was a part of the primary objective.

Furthermore, we recognized that State regulations required inservice training in mental health for nursing home operators. We wished to direct the content of these inservice training programs because the content was not clearly defined, and we believed that the time had come to incorporate more information on good mental health practices in these programs.

The Pilot Program

The philosophy, educational methods, and objectives which formed the foundation for the present project were an outgrowth of a previous pilot program. In September 1971, the staff from the Geriatric Unit of the Massachusetts Mental Health Center had met with the staff of the Boston University School of Social Work, Division of Continuing Education, to discuss the development of a program for nursing home education in mental health. Although the staff of the Boston University School of Social Work agreed with the objectives of the Geriatric Unit, they added another dimension in their emphasis on training people in adult education theory and methods of teaching. Furthermore, both institutions recognized the need to establish an educational process whereby those being trained would, in turn, run their own inservice programs.

The Boston University School of Social Work had a National Institute of Mental Health (NIMH) grant for the pilot project of training of trainers in mental health, and it was agreed that this was the direction in which we would collaborate. This agreement led to the formation of a committee of three to think through a proposal to train a select group of employees of nursing homes in mental health principles so they, in turn, could train others.

Training Teams Established

After a 7-week training program for the 16 faculty members, they were assigned in teams of four to go to the four different geographic units of the catchment area. The teams were composed of four physicians, four psychiatric nurses, four social workers, and four nursing home administrators (who were registered nurses). In these training sessions training objectives were developed, methodology considered, adult education theory discussed, and a curriculum was written for the six-session seminars. The teams were interdisciplinary.

Of the 158 persons attending, 124 persons from 35 nursing homes and corporations attended at least five of the six sessions and received certificates. The curriculum included a consideration of mental health issues in all phases of nursing homelife, from referral and preplacement planning, through discharge, transfer, or death. Many persons attending the sessions agreed to establish similar programs in their own nursing homes, based on the content of these seminars.

Nursing Home Education Project

Because of the experience in the pilot program, when the Nursing Home Education Project by NIMH was awarded, we already had all the community contacts, plus commitments from a number of homes, to establish inservice training programs after we taught them how to teach. New homes, having heard of our previous work, asked to participate and other institutions—some general hospitals and some State hospitals—either wanted to refer nursing homes they were working with to our sessions or wanted to observe our program directly.

Although we wished to use the Massachusetts Mental Health Center catchment area as the center for developing new curriculum and exploring teaching methods in depth, we also saw the need to expand beyond this small geographic unit to stimulate other areas to develop nursing home inservice training programs.

Subcontract to Boston University School of Social Work

Although the contract specified that the program was a collaborative one, the funds had been allotted only to the Massachusetts Mental Health Center. Therefore, the Massachusetts Mental Health Center drew up a subcontract with the Boston University School of Social Work to establish training programs for persons who agreed to teach in nursing homes in their catchment area.

The Project Director

The project director's role was defined as primarily administrative. In addition to the administrative duties, she would act as liaison with Boston University School of Social Work, to relate to the National Institute of Mental Health and the Massachusetts Mental Health Center, and to represent the project on a committee composed of those professionals working on mental health continuing education projects in this area. This committee met monthly to discuss methods, techniques, philosophy, evaluation problems, and theories. We shared experiences and learned from each other. Our main concern was how to make continuing education an effective agent of change. The project director also taught in several workshops and led a number of small discussion groups.

Advisory Committee

To have adequate communications, to meet the nursing homes' needs, to establish good public relations, and to gain widespread support, a new advisory committee made up primarily of nursing home representatives and a few key community people was appointed by the project staff. Several meetings were held during the year.

Adult Education Model

In beginning the contract, we mutually agreed that philosophically we wished to continue to base the project on the adult education model, in which those persons we trained would participate actively in the process. They would define their educational needs, establish their learning goals, and their educational contract within their personal lifestyle and within the organizational structure of their institutions. The faculty would be expected to be well versed in group dynamics and would use a variety of educational methods. Didactic input would be only one of many methods. We recognized that all adults taking the various seminars and workshops would be bringing their accumulated knowledge, their life experiences, and their attitudes and prejudices to the workshops and seminars. If we were to be able to teach effectively, these attitudes and prejudices had to be openly acknowledged and discussed.

Two teaching tracks and one demonstration project were ultimately adopted:

1. Both in the Massachusetts Mental Health Center catchment area and in the seminars and workshops conducted by the Boston University, *Training of Trainers* courses were established. We believed inservice training would be most effective and most continuous if a group of people, working either in nursing homes or closely with them, could be taught how to teach. They would then agree to teach in as many nursing homes as possible.

The Massachusetts Mental Health Center trained 10 employees from nursing homes and did followup on all their groups; Boston University had 48 professionals from four State hospitals and one VA hospital who participated in the training sessions and then reached out individually or in teams to conduct inservice training programs in nursing homes. Thirty such groups were formed. Thirty-seven persons were in the Vermont workshops who, in turn, are now teaching in nursing homes. Fifty-one persons from the Massachusetts Nursing Home Association attended a 1-day workshop, and although we cannot say they are all planning to teach, a number indicated that teaching was their assignment.

2. In the Massachusetts Mental Health Center catchment area, we departed from the exclusive *Training of Trainers model*, and, in addition, had workshops and seminars for nursing home and hospital employees.

3. Finally, although not referred to in the original National Institute of Mental Health contract, a program previously established by the Geriatric Unit, MMHC, was expanded and incorporated—the demonstration of group therapy for residents in five homes to help the homes see the value of such an experience for the residents. One social worker, six social work students, two community nurses, and one attendant (Massachusetts Mental Health Center) volunteered to co-lead these groups. Supervision was offered by the project director and the head of the Community Nursing Department of the Massachusetts Mental Health Center, who negotiated the establishment of these groups with the administrators and head nurses of the five homes.

In each group, a staff member of the home accepted the role of recorder as a way to observe and to learn the group process in order to ultimately take over the group. Although each group had its unique problems arising out of institutional characteristics and the kinds of residents in the home, all but one had an interesting and positive experience. In fact, the leaders were enthusiastic and several groups were continued after the original leaders departed.

The Massachusetts Mental Health Center Project

The overall objective of this project was to provide a nursing home education program that focused on the mental health needs of the elderly so that there would ultimately be some improvement in care and service to residents in long-term care facilities.

The need for training in mental health principles was spelled out clearly during the preliminary planning phase of this program when a great deal of effort was put into outreach and community work. Invitations were given to staff of responsive nursing homes to participate on the Advisory Committee to the Nursing Home Education Project. The Advisory Committee determined needs, suggested specific educational areas, and approved final plans for the year-long educational undertaking that combined 1-day workshops, seminars, and individual consultation.

The real challenge for this project was to provide an educational experience for nursing home staff that would have some real impact and staying power. Of course, this staying power is a problem that all educators face and has to do with many factors beyond the immediate teacher-learner interaction. Whether education can, in fact, be a powerful tool for change or not depends considerably on the educational model which is used and on the educational philosophy inherent in it.

Although a variety of teaching methods can be used, for our purposes a small group discussion model was found to be the most successful. The degree to which the participants (learners) were involved in the group process seemed to determine the degree to which they were similarly engaged in the learning process. Active, verbal participation, mutual sharing of experiential knowledge, respect for each member's contributions, group determination of objectives and direction—all created an atmosphere for experiential learning which appeared to have some real impact on the participants.

The educational model itself, therefore, was a key factor in whatever successes we experienced during our year-long educational effort. In addition to the educational approach which was used, we made every effort to design and structure a program which would meet the diverse needs of the nursing homes in our catchment area.

There were some 50 homes in our area, ranging from small, 22-bed converted single family homes, to 240-bed modern institutions with hospital facilities, day-care programs, and sheltered workshops. Some homes saw practical value only in sending one or two staff members to occasional 1-day workshops for stimulation and "some new ideas." Others were motivated to send staff (administrators) only to fulfill State licensing requirements. (Administrators must get credit for 16 hours of outside approved adult or continuing education courses to have their facilities licensed yearly.) Still others saw great value in any kind of educational effort but were hampered in their attempts to avail themselves of what was offered because of staff turnover, shortages, and emergencies which arose.

Of the staff from the 45 facilities in our catchment area which participated in the program in varying degrees, only 14 nursing homes registered for the seminar on *How to Teach and Set Up Inservice Education in Nursing Homes*. That is to say that most of the staff from the nursing homes participated in workshops and seminars that were designed, staffed, and implemented by an outside group (Nursing Home Education Project). The participants' only responsibility was to register and attend the *How to Teach* seminar which was designed to train a staff person from a facility to return to the facility and implement an internal ongoing inservice education program dealing with the mental health needs of the elderly. Of these 14, only 10 met the minimal requirements for enrollment. Of this starting group of 10, only 6 completed or were allowed to complete the seminar and were able to establish and carry out inservice programs within their facilities.

Despite the attrition rate on this *Training of Trainers* phase, it was considered important that we structure a program that would meet the needs of those homes which were able to make a bigger training commitment and wished to develop the capability of running ongoing education programs within their own facilities.

This two-pronged educational approach will now be described in greater detail—first, the series of workshops and seminars which provided stimulation and content and which focused on specific problem areas; second, the seminar to train nursing home staff to develop and teach inservice education programs.

The overall program consisted of five 1-day workshops, three 8-week seminars (16 hours each), and one 12-week seminar.

One-Day Workshops

DEATH AND DYING IN A NURSING HOME

This workshop dealt with attitudes toward death and the way these attitudes interfere with the staff's ability to talk with and comfort the dying person and his family. Small groups were formed to focus on two problems:

1. Administrative procedures for dealing with death which reflect an awareness and sensitivity to the impact on other residents and staff.
2. How to talk to the dying person.

The initial presentation was given by a physician from the Tufts University Medical School and his presentation was followed by that of two nurse practitioners of the New England Medical Center. After the talks were given, three groups were formed, one for the administrators and two for caregivers. In the first group, policies in the homes concerning the handling of death and dying were discussed in some detail.

The nurse practitioners leading the two

small groups of caregivers stressed how to talk to the dying person. Both roleplaying and discussion were used in these groups to facilitate experiential learning.

Seventy-five participants from 32 different facilities attended. The participants were made aware of the sometimes critical role that they can play in the life of a dying person.

MAXIMIZING POTENTIAL FOR A GOOD NURSING HOME PLACEMENT

In this workshop the problems of placement were considered and a careful examination of preadmission and postadmission practices were examined. Efforts were made to bring hospital and nursing home admitting staffs together.

The objectives for this workshop were:

1. To develop more effective placement procedures and
2. To develop better communication between hospitals and nursing homes.

The chief of Social Service of a local hospital, and the vice-president of the nursing home association and the director of a nursing home were the key resource people. Of the 54 persons attending this workshop, 21 represented 13 hospitals in the area, and 33 were from 19 nursing homes.

After the initial morning session, the presentation focused on placement problems from the hospital's viewpoint and as seen by the administrators of the nursing homes. In the small group discussions which followed, a careful examination was made of current preadmission and postadmission procedures.

Although our objectives were to develop more effective placement procedures and better communication between hospitals and nursing homes, it was soon clear that these goals were unrealistic for a 1-day effort. Nevertheless, communication was opened up and the need for followup sessions became evident. Several sessions would be required to improve communication to a point where a working committee could set in motion plans for more effective placement procedures. Actually, many of the professionals present voiced the need for more dialog between the two types of institutions and expressed a wish for future action in this direction.

WORK WITH FAMILIES

The way in which the nursing home staff relates and involves the family in the continuing care of the resident affects the quality of living in a nursing home. A faculty member of the Boston University School of Social Work made the presentation.

Most of the 50 persons who registered were nurses or social workers. A few administrators also participated. Our chief objective was to help participants understand that the way the staff of the nursing home relates to and involves the family in the continuing care of the resident greatly affects the quality of living in a nursing home.

Emphasis during the discussion was on specific techniques for working effectively with families during the intake process and thereafter. Roleplaying and small group discussions were used in the afternoon to facilitate concrete problem solving in this area.

PSYCHOPHARMACOLOGY

Two workshops were held, one for physicians in the nursing homes of this catchment area and the other for all personnel in the nursing homes. Of the 68 physicians who were invited by mail and with followup personal telephone calls, 39 registered and 31 actually attended. A co-director of the psychopharmacology laboratory, Harvard Medical School, spoke on the use of psychotropic drugs for the elderly, their side effects, and their interaction with other drugs. The participants were attentive but their questions indicated that they were unfamiliar with much of the data offered.

The second 1-day workshop on psychopharmacology was held at a nursing home and was open to all nursing home personnel in the catchment area. Interest was high among the 33 persons who registered. The speaker was assisted in the discussion group sessions by two residents from the Massachusetts Mental Health Center. They discussed case material that had been prepared in advance from participating nursing homes.

Although participants showed a great deal of interest and the material was well presented, the content seemed somewhat overwhelming to many of the nurses and nurses aides in attendance. More time would be needed to give a staff a real working knowledge of the uses and side effects of psychotropic drugs. There was also considerable discussion of the communication barriers between physicians and caregivers. Some suggestions for remedy were offered, but again more work and time were needed to overcome these difficulties.

HOW DOES IT FEEL TO GROW OLD—REALLY?

This session was presented by staff of the Equinox Institute, a private group focused on the issues of death and dying. Films, video tapes, songs, and discussions were all used to help participants focus on the feelings and perceptions of older people. Packets of materials containing relevant stories, poetry, and song lyrics were also distributed. Sixty-two persons attended the workshop. Twelve elderly residents from the nursing home participated actively in the morning discussion.

Used effectively, films, songs, and video tapes can stir up feelings, engage interest, and stimulate discussion about matters which are often difficult to discuss and which occurred at this particular workshop. The response was positive. In retrospect, however, we felt that the impact could have been heightened had we formed smaller groups for more intimate and thorough discussions. Again, so much material was presented that there was not enough time for indepth handling of it.

Summary

In summary, all our 1-day workshops were successful if we look at the general response and interest evoked. If they were to be evaluated in terms of real impact and staying power, however, they would, of course, fall short. It is important to see the value of 1-day workshops in realistic terms. They do not have long-lasting educational impact nor do they, in and of themselves, create much in the way of attitudinal or behavioral change. They do, however, stimulate and provoke interest in a problem or subject area. They can bring people together and provide an opportunity for social interaction, sharing of experience, exchange of ideas, and gaining of new knowledge. They can be used effectively to help generate the interest and motivation for further learning. They can be excellent public relations vehicles for developing an important sense of community among nursing homes. To this degree, the monthly coming together of health workers in the informal, serious, and semisocial atmosphere of a 1-day workshop can effectively reduce some of the isolation, stigma, and low self-esteem experienced by many nursing home employees.

These are all valuable credits and certainly justify the use of 1-day educational workshops. They must, however, be followed up by more sustained efforts if any real social change in the care and delivery of service to residents is to occur.

Eight-Week Seminars

The three 8-week seminars (2 hours per week) were scheduled to run in sequence. Participants were not required to take more than one 8-week seminar, but they were eligible to attend all three. A certificate from Boston University and Massachusetts Mental Health Center was given to all who took two or more of the 8-week seminars, and the Board of Registration of Nursing Home Administrators for continuing education credit approved 16-credit hours for the administrators of the nursing homes. Enrollment was limited to about 30 people in each seminar.

BEHAVIOR PROBLEMS IN NURSING HOMES—A MENTAL HEALTH VIEWPOINT

The content of this course centered around management problems. These problems are a continuous source of difficulty in most nursing homes. This phase describes any behavior which is disturbing to other residents or staff. Issues of sexuality, alcoholism, or psychological adjustment were high on the list.

The seminar was designed to discuss major adjustment problems and to offer ways of coping with them on two levels:

1. Immediate first-aid measures to deal with the crisis aspect of the problem.
2. Preventive measures which go beyond immediate control and involve an understanding of why people act the way they do given the physiological and psychosocial process of aging and the problems of adjustment to long-term institutional care.

A psychiatric nurse with a Ph.D. in psychology and with wide experience in nursing homes and geriatrics was recruited to teach this seminar. Thirty-five persons enrolled representing 20 different nursing homes, ranging in size from 22 beds to 240 beds. Those who attended included 4 administrators, 14 directors of nursing and nursing supervisors, three nurses, two licensed practical nurses, and nine aides.

In addition to dealing with general kinds of behavior problems and specific illustrations of each major type of behavior, the instructor spent considerable time focusing on staff needs, feelings, and attitudes which could critically affect the way in which one was prepared to meet patient needs and cope with patient and resident behavior. This emphasis on self-awareness and self-knowledge was extremely stimulating and exciting to some participants, although others were understandably threatened.

Although most of the participants in this seminar evaluated the results positively, there were some negative reactions. It is unusual to be 100 percent successful with a group, particularly when dealing with difficult and highly charged material. We felt that the group was too large, the setting somewhat uncomfortable and noisy, and the composition of the class too varied and changing. Before we realized what was occurring, a number of persons who were unable to attend sent substitutes in their place each week. These substitutions resulted in a large, constantly changing group during the early sessions. These difficulties were caused by poor preliminary planning rather than by poor teaching. These problems were corrected by the time the next seminar started.

GROUP TECHNIQUES IN WORKING WITH THE ELDERLY

Because nursing homes are group living experiences in themselves, all who work in them can benefit from this type of course because the actual experience of a small group seminar can become a laboratory for learning.

The objectives of the seminar were:

- to increase the sensitivity of group process and dynamics
- to develop specific techniques for group leaders
- to know when to use group techniques and with whom to use them
- to offer practical suggestions as to the kinds of activities that may encourage remotivation and involvement with others.

Thirty-five persons from 21 different nursing homes registered for the seminar. The enrollment included four administrators, seven directors of nursing, seven aides, nine social workers, five nurses, and three licensed practical nurses.

ESTABLISHING A THERAPEUTIC MILIEU IN NURSING HOMES

The overall climate or atmosphere in the nursing home is important if residents are to make maximal use of care facilities and maintain healthy levels of functioning. The administrative style and procedures determine the ways in which staff relationships function and, therefore, with the ways in which interpersonal group living problems of residents are resolved.

Thirty-four persons registered for the seminar from 21 different nursing homes. This seminar was open only to administrative and nursing home supervisory staff level. We believed that the exchange of ideas would be more candid if restricted to top level staff and that changes, if they were to come, would be facilitated by involving key administrative personnel. Of the 34 persons registered, 14 were administrators and 20 were directors of nursing or nursing supervisors.

A director of clinical social work and a clinical nursing supervisor of the geriatric service in a hospital co-led this seminar.

When the seminar was planned, two assumptions were held. First, that the overall climate or atmosphere in the nursing home is important if residents are to obtain effective use of care facilities and maintain healthy levels of functioning; second, that the administrative style and process determine the way in which staff relationships function, and, therefore, with the way in which interpersonal group living problems and relationships of residents are handled.

These assumptions formed the backdrop against which this seminar focused on the dynamics of group life within an institution and its effect on both staff and residents. In so doing, the group spent considerable time trying to understand their institutions and milieu in terms of where their home belonged on a continuum ranging from deinstitutionalized to highly institutionalized. The group analyzed the frequent contradictions or conflicts between planning therapeutic clinical changes and administrative interests. Lastly, efforts were made to understand and appreciate the conflict and competition between different levels of staff. It was clear from the exchange of ideas that conflict frequently causes staff to ignore each other and the estrangement does not allow for flexible use of skills. Sharp competitive mechanical role distinctions militate against the development of a therapeutic milieu.

This seminar started slowly. The two instructors were not thoroughly comfortable with their co-leading roles and the material was too abstract for many of the participants. The two leaders did not provide enough initial input for a group of this size.

Because of poor presentation and complexity of the course content, a third of the members of the seminar had dropped out by the third session. For the 20 or so who remained, participation was good and the evaluations they made were positive. Many of those who stayed with the course became intensely involved.

As a result of this seminar, two homes initiated a policy of having members of the staff meet with groups of families. Another home is planning to eliminate the wearing of uniforms. An administrator decided to develop a council for residents which encouraged residents to participate in home problems and decisions. Others spoke of attempting to change longstanding attitudes of staff members with a different approach.

HOW TO TEACH AND SET UP INSERVICE EDUCATION IN NURSING HOMES

The goal of this particular 12-week 2-hour seminar was to train personnel of nursing homes to set up and teach effective inservice education programs that emphasized mental health principles in the care and delivery of service to residents.

The training included lectures, discussions, and structured experiences. The groups were to be small and experientially based, and an onsite followup consultation was to be provided as needed.

The seminar required a commitment from participants to initiate an inservice education program in their nursing home at the completion of the 12 scheduled sessions. Supervision and ongoing followup consultations were available at whatever point this occurred. The seminar was open to any staff member who had been given the responsibility within his or her own facility to give inservice training.

Of the 14 participants who came to a preliminary group meeting, two were social workers, one was an administrator, one was an aide, and 10 were nurses. Several persons were not accepted because they lacked adequate administrative support or had so many internal staff problems that it would have been premature and unrealistic to attempt an inservice program at that time.

Of the 10 homes from which staff were registered in this seminar, representatives from two withdrew almost immediately. The reasons given involved staff leaving and resultant temporary shortages. Of the staff from the eight remaining homes, staff from two others also withdrew midway through the course. One of these persons when interviewed by our research assistant claimed that she "found the seminar personally useful, but our administrator feels that there are more important ways to spend staff time."

The staff of six homes completed the seminar. The group of nine persons (two each from three of the homes) consisted of one nurses' aide, one administrator, one licensed practical nurse, and six nurses. Attendance was excellent and the evaluation by participants positive.

Each participant, despite the uniformity of the objective experience (everyone was exposed to the same material), perceived the training differently and valued it in terms of their own unique background and need.

There were many indications that this aspect of the program could well be expanded. Several participants have completed their first series of training sessions within their homes and have held graduation ceremonies for their trainees, complete with certificates, speeches, food, and flowers.

There is little doubt that this kind of educational training, somewhat akin to an apprenticeship experience, has both staying power and potential for long-range impact and change within the nursing home community.

The total registration was 431 persons and the overall program involved staff from 45 nursing homes, many of them participating more than once and sending more than one representative; 16 hospitals participated with representative staff; 49 visitors attended; and 18 faculty persons and staff from the Nursing Home Education Project participated at all functions.

III. Report of the Boston University School of Social Work, Division of Continuing Education

Introduction

The initial mandate for this project centered around developing a model to train nursing home staffs in the New England area in principles of geriatric mental health. Geographically, we believed it would be impossible to offer mental health inservice training directly to nursing homes. Given our staff of one and our limited travel budget, we would have reached few people.

Therefore, our initial efforts were focused on finding some way to reach a large number of nursing homes and devise some method so that the inservice programs we developed would continue after the 1-year grant was over. We talked with nursing home employees at all levels and became familiar with their needs and problems. Because State regulations are rather nonspecific about educational requirements, such programs have low priority for nursing homes, most of which are proprietary.

The other focus of our preliminary investigation and assessment of various possible models was to examine the agencies which had ongoing relationships with nursing homes. We expanded this notion somewhat as we proceeded to include agencies which were not currently involved with nursing homes but wanted to become involved in some way.

A series of initial contacts were made which included the Departments of Mental Health in Massachusetts, Vermont, and Maine, as well as contacts in New Hampshire and Rhode Island, stemming from previous work that had been done by the Division of Continuing Education in these States. Through these contacts, we made some initial assessment of needs and interest. Several States, notably Maine, seemed to have several programs already in operation. Of the other New England States, Vermont expressed the greatest interest and willingness to pursue possible programs. In Massachusetts, we began to explore more extensively the possibility of developing programs with the State hospitals.

As a result of numerous discussions with these various agencies, a model began to emerge, one based generally on the concept of *Training of Trainers* which Boston University had previously developed. We believed we might have the greatest impact, both in terms of numbers and in terms of longevity, if we identified a group of mental health professionals from these various hospitals and community mental health centers, and devised a program to train them how to teach. They, then, in turn could offer as part of their agency job, inservice training on mental health issues to nursing homes in their areas. This training would insure that a much greater number of homes would be reached on an ongoing basis than we could ever hope to accomplish if we tried to offer such inservice training directly.

An intensive curriculum on how to set up inservice programs in nursing homes, how to develop one's potential as a teacher, based on adult education methodology, was developed.

We envisioned this seminar as a 12-week program, each session to run for 2 hours. Extensive followup was planned and a requirement for participation in the seminar was that each participant, during the course of the seminar, would develop and begin teaching an inservice program in a nursing home. This requirement was needed for two reasons. First, it would insure maximum benefit to nursing homes in that no one trained could use up a slot in our seminar and then decide they didn't have time to do the nursing home teaching or that they would do it at some vague future time. Secondly, it was educationally more productive to combine practice with theory and learn from real problems rather than by hypothetical situations.

The next step in the process was to offer the program to the various hospitals and centers we had contacted. We expected each institution to send one or two people for us to train, resulting in a total group of 12 to 15 learners. Instead of designating one or two professional persons on the staff to participate in such a seminar, each hospital requested their own program. One hospital indicated that they hoped we could eventually train 20 to 30 of their staff who would be able to offer nursing home inservice programs.

Such a response is because the hospitals are placing more patients in nursing homes. This policy is in line with the current emphasis away from large centralized institutions and toward greater use of community-based facilities. Helping the community to develop the expertise and knowledge to keep patients in nursing homes or other community facilities, rather than dumping them back into the hospitals at the first sign of difficulty, is a role most of them are interested in pursuing. In addition most of the hospitals have contractual agreements for followup consultations with the nursing homes in which they have placed patients for 1 year. It was the feeling of the staff at several of the hospitals that if their staff could begin to offer ongoing continuing education to the staffs of nursing homes, a more solid base of knowledge would be established, and this knowledge would insure more appropriate use of crisis consultation.

The result of these contacts was the development of five separate seminars. The seminars were held at the hospitals which are identified by the letters A-E.

Hospital A

From its inception, the group from hospital A had a number of problems which continued to plague us throughout the sessions. The initial communication from the administrator to his staff was unclear, and it was not apparent until later in the sessions that we should have spent more time developing mutual definitions and exceptions. A great deal of time was initially spent merely finding a time which was acceptable to everyone.

This group was composed of a unit of young psychiatric community nurses and a second unit of older nurses and experienced aides. Both units were already involved in ongoing relationships with nursing homes in their catchment area, and both groups were initially pleased to have contact with each other. An undercurrent of hostility, however, developed on the part of the younger nurses, fanned by one of their unit who was by turns sullen or openly hostile. A great deal of time was spent in trying to defuse this situation. There was, also, difficulty in finding an appropriate meeting space, and this problem was never solved.

Despite these drawbacks, however, a considerable amount of material was covered with particular emphasis on practical specifics. Almost from the beginning, each of the participants had started a group; and although the initial sessions found them anxious, the actual teaching gave the participants a sense of confidence. Both units had decided that such teaching would constitute a regular part of their jobs and each nurse or aide was given ongoing responsibility for one or two homes in their catchment area. Most of the homes approached were responsive and programs started smoothly.

The model presented stressed the need for administrative support and this support was easily obtained, possibly as a result of their previous relationship with a home. The community nurses were more highly structured in their initial approach, falling back often on nursing material. There was a considerable change, however, as things progressed and, when second groups were started, they were different—more learner oriented, informal, and geared toward mental health issues. The aides began more informally from the start—two of them working as a team. The feedback from the home in which they taught was positive and they were asked to continue. The feedback from all the groups was positive and substantial progress was made in the nursing homes, particularly their views of inservice training which they now believed worthwhile in theory and highly desirable in practice. Ongoing followup unfortunately was not possible with this group because of time commitments.

Hospital B

Training in hospital B began with a large group of about 15 participants whose attendance was erratic. It finally stabilized at eight. The dropouts resulted, again, because of scheduling problems and misunderstood expectations. It became clear after beginning a number of groups that the question of developing consensually validated expectations was critical. With this group, time was spent defining our purpose and goals—which resulted in several people deciding this training was not for them. What remained was a more homogeneous group clearly focused on nursing home inservice programs. Because members of the group also believed that they needed more mental health content as well as teaching method, each learner selected a topic she was interested in pursuing and developed material which she later presented (taught) to the rest of the group.

Subsequent learning was structured around discussion and analysis of these teaching and learning presentations. We not only discussed content, but each person did some actual teaching with critical feedback in a comfortable situation. Presentations ranged from fairly straight-forward presentations of material to a beautiful dramatic dialog on death and dying which was written by two of the nurses in the class.

Films and some basic sensitivity exercises were used by others. In general, the format was successful in that it combined the learners' two stated needs—for more content and method—in an integrated fashion. It also became an immediate laboratory for looking at the variety of relationships the teacher could have to the learners. This method seemed important with this group as they were all initially confused and uncomfortable with a teacher who didn't stand up front and lecture.

Considering the initial resistance to a more informal shared teaching model, the final results with this group were gratifying. In the evaluation, they believed the objectives set for the seminar had been met, and each had been pleasantly surprised by how they were enjoying their teaching experiences. Followup with this group was mainly by the telephone with individual persons. Each of the group members came from a different unit or service and it was impossible to extend the group sessions past the 12 weeks originally contracted.

Hospital C

The group at hospital C was initially intended to be interdisciplinary. The final result, however, was a group of social workers with bachelor's degrees, selected by the working contact at this hospital who was the Director of Social Service. Had it been possible to teach another group there (as had originally been planned), we would have worked through the Director of Nursing.

This group proved to be one of the best in a number of ways. Although they had all worked in the same unit for several years, this experience was the first they had really had as a group. As they worked out their problems and issues in forming what was to become a cohesive, supportive team, we analyzed the processes and translated them into nursing home terms. The time we spent working through some of their staffing problems also proved to be a living laboratory on two levels. It was a most vivid demonstration of the need to begin any learning experience, but most particularly one dealing with mental health, with what the learners defined as their pressing issues. Everyone agreed that had we forged ahead with a preplanned curriculum almost no learning could have taken place.

Although this approach is one of the most difficult concepts for new teachers to grasp, their problems proved most fortuitous. It was also a positive experience for them because it gave them a first-hand experience with a situation which invariably comes up in every nursing home—namely staffing and intrastaff issues or conflicts. Having worked through problems, they were better prepared for some of the issues which cropped up over and over as they began teaching.

Because of scheduling difficulties, this group was not able to begin their groups until the end of the 12-week seminar. The delay caused anxiety which, at times, was not productive. It is highly desirable to have the trainees begin their teaching experiences as soon as possible. This procedure insures that the learning is real and problem centered, rather than theoretical or hypothetical.

This group experienced considerable growth on three distinct levels. Almost all of the goals we had set in terms of cognitive knowledge were achieved, despite the amount of time we initially spent on noncognitive problems. Enormous growth took place in their functioning as a staff group. This growth was especially evident in terms of their teaching roles as they became mutually supportive of each other, acted as resources to each other, and were exceedingly productive in mutual problem solving. The results for the homes were more successful inservice programs.

Many of the group members also experienced a great deal of personal growth which had positive effects on their role as teachers. Several of them worked in teams, and this teamwork tended to reinforce the learnings and the growth. The teams (in all five groups) were self-selected and worked together exceedingly well. During our evaluation, they decided that they wanted to continue meeting as a group, so we developed monthly followup sessions which were problem-solving clinics. These clinics proved effective and gave each member greater confidence in their own groups. The knowledge that they had a place to come with their teaching problems gave them a freedom to try things they might not otherwise have tried. It also prevented them from being discouraged or from discontinuing teaching.

It was also evident that many informal discussions and much analysis went on during the month. Whenever a "crisis" would occur, they could telephone for consultation and support. The positive results from this group had many positive effects outside the group as well. The staff atmosphere in their prime setting took on a more confident, cohesive tone, and they expressed feelings of being less isolated in their job setting.

Hospital D

The group at hospital D was formed from self-selected members of their existing interdisciplinary community care unit. This unit had been functioning as a team for a number of years, and they were responsible for making all nursing home placements for VA patients. Each member of the team covered specifically designated homes in terms of placement and followup. All the group members were extremely knowledgeable about the homes they covered, both in terms of the facility and the personalities of the staff and the availability of community resources. This group was most interested in seeing whether inservice training in the nursing homes would result not only in better patient care and more appropriate use of consultation, but also whether they could help some homes develop to the point that they would become appropriate placement potentials. Currently, there were numerous homes in their area in which they would not place patients because care did not meet their standards.

This group moved quickly into the content of the seminar and seemed able to define issues and goals rapidly. This ability was attributed to the fact that they had all worked closely together for many years. Discussions were always lively and fast moving and they had little trouble with shared responsibility and a less directive model of teaching. Several of them decided to do their teaching in teams and were successful.

They began their teaching toward the middle of our seminar and in the remaining sessions used many of their "problems" to discuss and illustrate the material. They also began thinking in terms of other formats they might use to reach more nursing home administrators and educate them to the mental health needs of the patients. One-day workshops or special seminars sponsored by the hospital were discussed. This group also spent considerable time defining realistic objectives for their groups. This type of discussion is especially important as unrealistic goals seem to be one of the prime reasons many educational programs in nursing homes have fallen into disfavor. This down-to-earth approach was a particularly important step in their goal of bringing some nonstandard homes up to their standards.

During our final evaluation the participants believed that we had met our stated objectives, as well as some unstated ones. They decided to continue meeting, and, therefore, we planned monthly group meetings for followup. Again, these were designed for problem solving and were found useful by everyone. The participants were particularly enthusiastic about an unexpected result in their inservice training for nursing homes. They found that it helped them to learn the staff members and vice versa in a way which had not been possible previously. These contacts seemed to be of mutual benefit and the participants saw all their contacts with the homes more productive as a result of this indepth two-way understanding.

Hospital E

The final group at hospital E was the largest, composed of nurses and social workers. They had not previously participated in ongoing, formal interdisciplinary efforts, and the results were a happy surprise for everyone. Many of the hospitals are plagued by interprofessional rivalries and contacts with other disciplines are strained. As a result of this seminar, the nurses and social workers in the group developed open channels of communication and a high degree of comfort and trust. This openness had effects far outside the confines of the group. The directors of social service and nursing were so pleased that they are making efforts to continue this pattern in other areas.

Defining expectations and becoming comfortable with each other took a little longer with this group, but as a result of not rushing this phase, the work accomplished later was sound and unusually productive. The teams were usually a nurse and a social worker which added to their comfort in teaching and offered the homes a well-rounded program. The unsolicited praise from nursing home directors about some of these teams was gratifying. There was one problem member of the class whose hostility and personal manner were difficult to deal with, and friction caused some problems in dealing with issues of group process in learning situations.

Interestingly, when they began to redefine their learning needs and goals, they pinpointed the dynamics of small group processes as a learning need. The group, in a similar fashion to the group at hospital C, changed and progressed dramatically during the course of the seminar. Cognitively, they felt they had learned much and the level of operation of their groups demonstrated this. Affectively, they also grew—in terms of a sense of self-confidence and willingness to risk themselves in trying new methods and in terms of their cohesiveness as a group. They became concerned, supportive, and creative in their relationships with each other. Many of the members who had initially resisted participation in the seminar now were the ones who were most interested in finding ways to continue their meetings. As with several of the other groups, we scheduled monthly followup sessions after the 12-week period was over.

Training Impact and Results

In assessing all the impact and results of these groups, it is evident that it was a positive experience for all concerned. It is clear that the need and interest on the part of the homes are present. Although there are certainly many homes which are not interested in inservice training, so many were hungry for our type of project that we had more applicants than we could possibly manage. Possibly those homes which were not interested need this type of training the most, but that would necessitate a project whose prime focus was not on the actual training but on working with administrators to bring them to the point where they could begin to see that they might possibly benefit from further training.

The model of training trainers was effective, as we reached a far greater number of homes than we could have any other way. Involving existing institutions was also productive, as they are all intending to continue offering programs to the nursing homes. It also seems clear that this involvement will enhance the communication and rapport between hospitals and nursing homes.

Nearly all the hospital staffs who participated were enthusiastic about teaching and planned to continue. They were interested in further training, and it was gratifying to see how much progress they had made.

Workshops

The other part of Boston University's project centered around several workshops which were offered in Vermont and Massachusetts.

In Vermont, we established contact with the State Department of Mental Health and the directors of their 11 community mental health centers. After proposing several plans, a planning committee was selected and we began working toward a 3-day workshop. The directors all felt that they were, for the most part, doing little to service the elderly in their areas and that this program would provide the gentle nudge which would propel them in that direction. To this end, they designated one or two people from each of their staffs to be trained. We made it clear that those persons trained had to begin inservice training in nursing homes. Vermont has a particular problem in that many of the homes are not licensed nursing homes but unlicensed boarding homes. Some attempt had been made to reach boarding home operators but without success.

Several planning meetings were held attended by the original planning committee, which had been designated by the community mental health center directors. These were people who, for the most part, were those who would eventually participate in the workshop and return to their areas and actually set up nursing home programs. In addition, there were two staff members from the Department of Mental Health. Also involved in the planning meetings were representatives of the Vermont Office on Aging, the Vermont Health Department, and the Vermont Nursing Home Association. It was felt important to include all these people at the initial stages, because their input in defining needs was of major significance. We also wanted to involve them as much as possible in the actual workshop so that the program would have a more indigenous quality.

The actual development of the specific format and curriculum was formulated by the project staff. We selected a format centered on small group discussions, with minilectures at appropriate points throughout the 3 days. Two presentations were made—one dealt with issues on aging and the other with issues of adult education methodology. An additional group was led by the Director of the Continuing Education Branch of Boston University. This presentation was to accommodate a number of people who had expressed interest in the adult education model we had developed but who were not directly involved in nursing homes. Many were, however, concerned with the elderly, and it was interesting to note that as a result of their involvement in this workshop and the followup one, they were working on the possibility of implementing the State hospital training trainers model, with the intention of offering some form of mental health inservice education to nursing homes.

The opening format of the workshop included presentations on the issues and problems of the elderly, particularly those in nursing or boarding homes in Vermont. These presentations were made by the Director of the Vermont Nursing Home Association and a member of the Office on Aging staff. These presentations of issues and problems of the elderly enabled us to get a realistic picture of the problems in a way that we, as outsiders, would have been unable to present.

FIRST WORKSHOP

For the first workshop, we had 37 registered participants. All attended the minipresentations and were then divided roughly into three small equal groups. The participants were staff from the community mental health centers, both social workers and nurses, and nursing staff from a number of nursing homes. Judging by the final evaluation, the impact of the 3-day experience was enormous. The desire for a followup workshop was shared by almost everyone. The fact that about two-thirds of the people actually came to the second workshop is an indication of the value of the first workshop.

There were, however, several people who did not benefit directly from the workshop. These failures resulted from a rather clear difference in level of knowledge about mental health concepts. The workshop had been planned on the assumption that participants would have some knowledge of the terminology used in the area of mental health. Although our object was to train trainers and not to directly teach mental health principles, those who did not already possess some expertise were unable to grasp much of what we were discussing. Had we had more time, we might have been able to meet their needs. It was clear, however, that part of the problem lay in how we had phrased the registration requirements. If we had been more specific, we could have avoided this problem. In the material we sent out prior to the second workshop, we were explicit in our expectations and the problem did not reoccur.

SECOND WORKSHOP—DEMYSTIFYING MENTAL HEALTH

Working again with the planning committee, we developed the second 3-day workshop. As a result of the experience in the first workshop, we felt that since we had the staff available we could add a new group of nursing home staff, aides, and licensed practical nurses to discuss *Demystifying Mental Health.* We received excellent cooperation from the Vermont Nursing Home Association in setting this up. This small group was fairly autonomous from the two other groups who had attended Workshop 1. Several planning sessions were held with them to develop a curriculum for this group. For most of the people in the group, this planning experience was their first experience at a 3-day conference and they were enthusiastic. The group was informal with emphasis on discussion and participation by all members. This conference was the first time for many that their experience had been valued and that anyone was really interested in what they had to say.

In the two groups that continued, we worked exclusively with the small groups. One group concentrated on experiencing and analyzing small group dynamics and the other group chose to concentrate on specific teaching techniques with time allotted for each person to do some practice teaching in the group and receive critical feedback.

OTHER WORKSHOPS—DEATH AND DYING, STRENGTHS OF THE ELDERLY, AND GROUP DYNAMICS

Two additional sessions were offered each evening—one on *Death and Dying*, the other on *Strengths of the Elderly*. Each person could schedule his or her program for evening, and they were encouraged to attend with a person they had not spent time with during the day. This procedure was reasonably successful in promoting a mix of people and fostering informal exchanges with members of the other groups.

Evening sessions had been held during the first workshop as well—with the same purpose of promoting interaction, as well as offering additional contact. At the first conference, evening sessions on *Death and Dying* were given and one was offered on *Group Dynamics*.

During the final evaluation our participants indicated that this second workshop was successful and that the 3-day workshops were worthwhile in terms of learning. The depth in which the material was examined was believed to be beneficial, and it would be difficult to achieve this and the sense of continuity in less time. All participants expressed the desire for more training and it was interesting to hear that, partially as a result of their positive experience with us, the Nursing Home Association is planning a further series of educational offerings for aides as well as nurses.

The final program which the staff of Boston University offered was a 1-day workshop for the Massachusetts Nursing Home Association in the northeastern section of Massachusetts. They had heard of the work we had been doing and they approached us to see what we could offer them. In conjunction with several of their staff, we worked out a format for four small groups and two minipresentations. Presentations were given on what it is like to live in a nursing home from the patient's viewpoint and the use of an inservice training model. Each of the small groups set their own priorities—the morning session generally being devoted to how to take this knowledge and turn it into an inservice program for their homes.

Living closely together they should talk with each other, know each other, and support each other's feelings. The co-leaders, in inviting the residents to join a group, told them that they could talk about anything they wished regarding life in a nursing home, that it would be nondirective, open, and confidential. For many, this was a unique experience. They had had few experiences with such an approach and constantly sought structure and agendas. Eventually, this stopped as they began to experience this new freedom.

Group members were selected with minimum criteria; even this varied among the homes. Those with severe hearing defects, serious brain syndromes, and very difficult speech problems could not be included. Also, we tried to avoid having only isolated, withdrawn people, because we believed more varied personalities and problems would make for greater interactions. We did not seek out the active leaders who were managing well unless we wanted such a person to lend the kind of ego functioning that was lacking in the group. Nor could we have all wheelchair patients because the aides balked at this.

What did the residents talk about in the groups? At first, these people, living together under the same roof, found it hard to talk with each other. The conversations were a series of unrelated statements; however, this changed as the leaders helped them relate to each other and to them. In the process of becoming acquainted, most learned for the first time a bit about each other's backgrounds, and this led to more individualization and to a lessening of labeling people by their obvious handicaps (as "the man with the cane", "the woman with the funny speech", etc.) or characteristics ("the red haired lady", etc.). After a while, they listened to each other and conversation became more connected, more coherent, and more focused on specific themes.

Food was one of the first issues they joined together to complain about. They reminisced about their cooking and timidly protested their present home's cooking. In one of the groups, while they at first requested the co-leaders act as their advocates with the administration, ultimately they were helped to voice their protests. To their surprise, positive results followed quickly. Other members of the home looked up to them at this point.

The most important issues ultimately were related to themes of depression and loss. Many could speak of it first in derivatives (recollections when their children had illnesses; news stories of fires in which families lost homes; friends who died of cancer); but after a while, they voiced their own loneliness, feelings of abandonment, family disinterest, and their anger at being incapacitated and in a nursing home. Death slowly moved onto the stage as members of the group first talked of things dying in winter, and then of serious illnesses of absent group members, and finally of several deaths in the home. Departed spouses were referred to and eventually real grief was dealt with. Holidays, such as Thanksgiving, Christmas, and Easter, brought the greatest flood of depression.

That they could listen to each other and support each other became the most important strength and movement in the groups. In one of these groups, after a number of weeks with these recurrent themes, the release from these persistent griefs through their ability to talk aloud about them led to a fascinating session where jokes, gaiety, and even a few dance steps took place. Parenthetically, in several groups, the student leaders came to the meetings even during the holidays rather than abandon the groups at that time.

Certainly, the formation of groups in nursing homes for purposes of developing greater social interaction, sharing feelings and ideas, and airing problems is hardly a new thought; but it is a rare experience when one explores the social structure of nursing homes. Our limited experience is so positive that I would recommend building this into the nursing home education projects to help nursing homes view the effects and the results. Since the concept of "home" in the appellation "nursing home" is too often missing as a medical model is employed, this type of demonstration could bring a new emphasis to homes and a new experience to residents.

Summary of Observations and Recommendations

The following are a series of observations we extracted from this experience and some recommendations we would like to record:

The data presented in this report reveal an action and group process program with strong nursing home participation and input. It reflects an educational philosophy directed to the individual person's needs and active participation in the learning process. This emphasis on the individual person was our approach throughout the program. Furthermore, we were concerned with the need for change and saw ourselves as change-agents; we hoped to make the life of residents in nursing homes better. We recognize, however, change is hard to measure: so much is not quantifiable, much is subjective, much is not easily recognized and may be subtle. Therefore, all we can hope for is that those learners who participated with us have looked at themselves to understand themselves better and handle their residents more sensitively. This change is the only kind we can really expect through our contacts with them. But we hope that by having actively engaged our learners, the changes they experienced will be communicated in the homes and in the way the residents are treated.

From the start, we were aware we could not adequately measure changes in nursing home residents directly attributable to our program. There were too many variables and extraneous influences at play. We felt that, at best, such a program can only assess the attitudes and knowledge of the learners, i.e., those with whom we had direct contact. It was only in the therapy groups that residents' feelings, responses, and changes could be assessed. We would like to see more research both of attitudes of staff and of the effect of therapeutic groups.

We would recommend that a careful assessment of why some invited nursing homes did not participate in the program be made in order that future programs comprehend their problems, attitudes, or resistances. Since our program was free of charge and since Department of Public Health regulations require in-service training, it could have been safely assumed all the homes would participate. A number of homes outside our catchment area requested invitations but 25 in the area refused to send anyone. An informal inquiry among some of them gave the following reasons:

- The State does not allow enough nursing and aide hours for patient care; therefore, they could not "'spare" anyone for education. These homes indicated they might be receptive to teaching teams coming to their homes. (However, we offered this service to one home and the home never "found" the time.)

- Some homes could not provide transportation to the seminars and workshops and felt too much travel time was needed. (All of the meetings were a maximum of 25 minutes from the most distant home. Most were 10 to 15 minutes away.)
- Mental health education just isn't high on the priority list.
- Mental health isn't "a problem", "because we don't take mental patients" or "because we refer them elsewhere if they get mental."
- Where poor labor relations and disorganized administrators existed, clearly preoccupations and energies were not directed toward education.
- The corporation has an education department; so why go elsewhere?

We found even that seemingly open, well-motivated, "enlightened" homes needed mental health education for their residents badly. Their definitions, their perceptions, and their interpretations seldom reflected what we considered good mental health principles. For example, one administrator, who attended all offerings for 2 years in a row, in the Therapeutic Milieu Seminar advised the participants that staff should not get close to patients because the residents would mourn the departures of staff or the staff might adopt some patients as favorites. Therefore, he shifted staff to different floors from time to time. Another administrator could not understand when we indicated no patient should be forced to join the group being formed. "It's good for them. We should *make* them join."

A problem to be overcome in nursing home education programs is discrimination against aides on the part of some homes. Many administrators and head nurses participated in the seminars because the State Licensing Board gave them credit toward acquiring or maintaining their licenses. They, therefore, came but did not allow the aides to join. Interpretation of the educational needs of aides and orderlies is much needed.

In each home establishing its own education program, it is necessary to help them understand the meaning of the educational process. Many see a once a month lecture or film as meeting State regulations. The frequency of educational meetings, their participatory nature, the continuity of content, and the active involvement of all present in the educational experinece need to be evaluated constantly.

More demonstrations of the value and use of groups, both activity and therapy, should be undertaken in nursing homes. Our findings show people do like knowing each other, being less isolated, being more sociable, and sharing feelings. They find meeting others supportive and meaningful and they feel it makes life more bearable. Actually, in addition, nursing homes could be helped to establish groups for children of parents being referred and for the visiting spouses and siblings of the residents to help them separate and the resident adapt to this new involuntary way of life.

A successful teaching of teachers programs should include a supervisory and consultative component for followup. We feel the model we employed was highly useful, readily establishable, and gave the results we sought.

The workshop on referrals between hospitals and nursing homes dramatized the paucity of communication between these institutions as well as the disorganized chance nature of the home finding. The dignity and wishes of the resident are all too frequently overlooked as hospitals pressure their placement departments to "get the patient out of here." The medical profession needs to be more sensitive to the importance of a good referral process. It isn't a bed that needs to be found, but a home, and this is lost sight of by many medical and hospital people. Nursing homes need to describe their resources to hospitals more carefully and hospitals need to determine patients' real needs. More communication between them is essential. A number of the workers in the hospital placement offices stated that they didn't have time to visit the homes to which patients are referred. Hospitals should know these homes firsthand.

Courses, seminars, workshops should use adult education methods and group dynamics in the educational process. Those participating uniformly responded favorably. Only a very few ultimately wanted the more didactic model.

Those taking the group process seminar would have liked a supervised practicum afterwards, similar to our followup in the *How To Teach* seminar. Unfortunately, we could not quickly and easily work that out. The *How To Teach* seminar was a useful and meaningful seminar and we wish we could have done more than just give the extra four sessions we scheduled at their requests. Our teacher, unfortunately, was not available. Such a seminar for nursing home personnel with followup and supervised practice is highly recommended. Activities workers and nurses were most interested in this.

We recommend most teaching be done in small groups and in the neighborhoods of nursing homes (where geography permits) to eliminate distances and travel, to bring neighborhood homes closer, and to encourage weekly meetings rather than their usual monthly ones.

There is an urgent need to educate administrators in particular on what is good education, why education in depth is needed, and that there are no educational shortcuts.

Administrators and head nurses (in other words, the policymakers) need to understand the meaning, value, and dynamics of relationship. Lack of awareness and lack of empathy are at the root of this, and reaching these people to help them shift in their administrative practices is essential.

Most people participating liked our interdisciplinary approach. It should be continued. In addition, we had patients come to the film program and they loved it, made many good observations and comments, and participated actively.

Some conflict between didactic and participatory discussion methods showed up in the evaluations. Interestingly, those in the 8-week seminars resolved it always in favor of the discussions while admitting they at first preferred didactic methods. The nurses aides, in the Vermont Workshop, stated the group process approach we used was foreign to them but after 3 days said they learned that they knew a good deal and learned more about their subject, themselves, and others.

In any future seminars for indepth learning, we recommend the following:

- Homes be told that the same persons should attend all the sessions (8 consecutive weeks) and send no substitutes.
- We suggest more training of trainers programs for those from homes willing and able to accommodate themselves to such a regime. In that event, consultation and supervision must be provided.
- We feel workshops should be used only for single topics needing special focus or emphasis (as Psychopharmacology, Death and Dying). Even here, 3-day workshops are much better than one if it is practical or possible to organize them on this time basis.
- Emphasis in all our teaching is needed on staff attitudes about themselves and their fears and feelings about their own old age. Also, their fears about mental illness and sexuality need greater emphasis.
- The adult education model should be used in all programs.
- Most nursing homes do not have adequate training for social workers and activity workers, and frequently do not define their roles properly or creatively. Generally, these are college graduates without special training. Special offerings to these two groups of nursing home staff would be of particular value.
- The need for a central clearing house for elderly referrals should be studied and explored. It is needed in Boston, recommended for Chicago; and we would guess all cities need some such organization.

Evaluation 1 Year Later

One year after the last sessions a followup questionnaire was sent to all those who attended. Completed questionnaires were returned by 58 percent of the participants of the seminars on "How to Teach Inservice in Nursing Homes"—51 percent of those attending the Vermont workshop and 33 percent of those attending from staff of local nursing homes.

"HOW TO TEACH" SEMINARS AND VERMONT WORKSHOPS

Seventy-five percent of the respondents who attended the "How to Teach" seminars actually set up the required inservice educational program during the training period. Thirty-six percent of them had started one or more inservice programs in nursing homes during the year following the end of the training. Many of those who had not set up any programs expressed a desire to set them up but other demands of their work took higher priority.

Among the Vermont workshop attendees, 61 percent started one or more programs afterward. The fact that many of the respondents worked in community-oriented clinics appeared to facilitate their inclusion of inservice training in their work roles.

A subgroup of the attendees of the Vermont workshop continued to meet and draw up recommendations for their State legislature concerning care in nursing homes.

An important determinant of whether or not programs were set up in nursing homes was the attitude of the administrative staff—positive attitudes were mentioned twice as often as negative ones.

Participants reported that they used what they had learned in the seminars to improve their teaching in existing inservice programs and in acting as consultants to staff of other nursing homes. The heavy emphasis on adult education methods was generally viewed as appropriate and useful. The followup suggested that careful attention should be given to selecting students who are in an organizational position that will permit them to take on a new role in inservice education.

WORKSHOPS AND SEMINARS FOR NURSING HOME PERSONNEL

Attitude changes and changes in the way they worked with individual residents were the most frequent outcomes identified. When asked how they were affected by attending the sessions, 30 percent of the attendees said their comprehension of resident problems had increased. Twenty percent said they used material from these seminars in their own inservice education programs.

Changes in nursing home practices and development of new programs were uncommon, though 16 percent of the respondents started group meetings for residents as a result of attending the seminar on group technique. Also, two nursing homes started group meetings for staff and one began a group for family members of newly admitted patients.

OTHER OUTCOMES OF THE PROJECT

Sixty-one percent of the attendees from local nursing homes rated it "very important" that they met and talked with people from other homes who had similar interests to their own.

Fifty-seven percent felt the sessions enhanced their job satisfaction and 10 percent said it decreased their job satisfaction. The most common reason given for this decrease in job satisfaction was a conflict between their desire to implement ideas learned during the sessions and conditions on the job which discouraged it. Twenty percent of the entire group had changed jobs during the year following the project.

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IV. North Texas State University

Evaluation of Continuing Education in Mental Health for Personnel of Nursing Homes, September 13, 1972—January 15, 1975

Growing concern for the quality of life of persons who are residents of long-term care facilities has led to an interest in increasing the knowledge, competence, and resourcefulness of the personnel working in them. The Continuing Education in Mental Health for Personnel of Nursing Homes (CEMH) program is an effort to do just that. It seems imperative that if long-term care facilities are to be devoted not only to physical care, but also to the highest possible quality of psychosocial care, educational efforts such as that represented by the CEMH program should become a permanent part of the long-term care facility's training efforts.

Mental Health in Nursing Homes

The problems are not new.[1] In recent years a number of facilities have recognized the need to improve the mental health of residents and have introduced programs to that end.[2] Furthermore, there have been several widely publicized demonstration projects that have developed innovative programs. (For example: the Therapeutic Community Approach at Ypsilanti Hospital, Lansing, Mich.; Reality Orientation at Tuscaloosa Veterans Hospital, Tuscaloosa, Ala.; The Priory Method at St. Mary's Priory Hospital, Victoria, British Columbia, and others.) As a result, a number of treatment modalities exist which include remotivation, reality orientation, behavior modification, milieu therapy, token economy, moral treatment, and operant conditioning. The proper implementation of each of these treatment modalities, however, depends on the ability to modify them to the skill levels, interest, and capabilities of a particular facility's personnel. Additionally, there must be support for such programs at the administrative level. It is not enough to have personnel capable of implementing the various treatment modalities unless there is commitment on the part of the administrator to support them.[3]

Constraints Affecting Program Design

One of the first things to consider in designing a program aimed at improving the mental health skills of personnel of long-term care facilities is the characteristics of the personnel themselves. Nursing home administrators differ widely in their characteristics with variations in level of education and receptiveness to new ideas being especially important to developing continuing education programs.

Variations are also extreme in the educational background and training of the personnel. These variations range from professionals who have some college training and may have advanced degrees to employees with few skills and who may be almost illiterate. In addition, the turnover rate is high, particularly in those positions where few skills are needed and the pay is low.

Nursing homes themselves vary widely on a number of dimensions: i.e., size, ownership, and level of care offered. Interest in and willingness to commit resources to psychosocial and therapeutic programs are not the least important of the dimensions in which facilities vary.

All these factors can be documented, and taken together they impose constraints on the design of the CEMH training programs.[4] The variation in homes, administrators, and other personnel makes it evident that the need for training in mental health varies widely and no single program could be designed to meet the needs of all homes. The high turnover rate results in the composition of a group of employees changing radically in a period of 2 to 3 years; thus, as much attention must be given to continuous training as to the content of the training itself.

The success of any program to identify, understand, and use mental health components in nursing home care is dependent on the understanding and acceptance of the program by the administrative staff. The staff must, in turn, recognize that the program will not only enable them to cope with the problems presented by aged residents but also will result in better care and an improved quality of life for the residents. The program should also appeal to the administrator as a means of assisting him with the problems of recruitment, training, and turnover of personnel.

Middle management (supervisory) personnel must support the program as a way of improving patient care and the quality of life for the resident. Employees working directly with the resident are the most important element in delivery of the treatment modality, and they must understand the program and support it as a way to make their work easier and more rewarding. These understandings formed the assumptions on which the CEMH training program was based.

Specific Program Objectives

The overall objective of the CEMH training program was the improvement of the quality of life of persons who were residents of long-term care facilities. Specific program objectives include:

- increasing the awareness of personnel of the psychosocial aspects of long-term care
- developing or improving skills of personnel in identifying and meeting mental health needs of residents
- developing an awareness of and ability to deal with the special needs of the mentally impaired
- facilitating a closer working relationship with mental health facilities, especially community mental health centers
- encouraging the development of continuing education programs in nursing homes.

Curriculum and Training Methods

The goal of the CEMH training program was to improve the mental health status of residents in nursing homes by improving the mental health awareness and skill of personnel caring for them.

The CEMH program included the following content areas:

- mental health aspects of aging and institutional living
- overview of treatment and preventive modalities (with emphasis on remotivation, reality orientation, attitude therapy, and behavior modification)
- the role of meaningful and enjoyable activities
- working with families
- developing working relationships with mental health centers, State hospitals, and other existing agencies
- communication and teamwork.

Throughout the training sessions, it was emphasized that (a) positive and hopeful attitudes will have a beneficial effect, just as negative labels and stereotypes become self-fulfilling prophecies, (b) closer ties with the mainstream of community life will benefit both the nursing home and its residents, and (c) each resident should be evaluated as an adult with both needs to be fulfilled and strengths to be maintained and developed.

Training methods were purposefully designed to include a mix of experiences, including lectures and feedback, panels, films, experiential exercises, demonstrations, role playing, small group discussions, and problem-solving exercises. In the sessions involving personnel working directly with the residents with little exposure to formal training, lecture-feedback presentations were held to a minimum. Also with this group, emphasis was placed on their therapeutic potential in the lives of residents to whom they have become central and significant figures.

The final wrap-up for each workshop was small group, problem-solving sessions involving a hypothetical situation but one which was immediately recognizable to all participants. Developing a plan for effectively addressing the hypothetical situation required the synthesis and application of all content areas presented in the workshops.

Training Format

Training was given in two 2-day workshops separated by a period of approximately 2 weeks. The first training session was offered to nursing home administrators or members of the administrative staff. The second workshop was directed to personnel working directly with the residents. A commitment to participate in this second workshop was a precondition to being included in the training program.

The first workshop was designed to demonstrate to the administrator and personnel of the supervisory level that two results can be expected from a positive program designed to improve the mental health of patients. These results were better satisfied residents who will participate more in the activities of the facility and better satisfied employees, especially those working directly with patients because they participated in this program. The second workshop was designed to help custodians, aides, service, and therapeutic personnel understand their vital role in improving the mental health of their residents by helping the employees to understand and cope with aging, illness and death, and to incorporate their knowledge, through new or improved skills and competencies, in their relationships with residents.

In all, 10 training sessions were offered, five for administrators or administrative staff designated by them and five for teams of personnel in the low skill positions designated by the administrator of the facility. (These data are for the first five CEMH workshops only. One has subsequently been held in Little Rock, Ark., another is scheduled in Corpus Christi, Tex., and there is the possibility of one for Louisiana. When the data from these are collected they will be analyzed in the same way and will in effect be a replication.)

After the conclusion of the workshops in each series for both the administrators and those personnel working in the less skilled positions, each participating home was visited twice by the project coordinator for purposes of consultation, technical assistance, and staff training. The visits were for one-half day each, spaced 4 to 8 weeks apart. Characteristically, the consultant was asked to conduct a 1- to 2-hour session for an average of 15 employees, followed by direct consultation with one or more key personnel. Occasionally, this service was provided by a local consultant who had participated in the workshop sessions held for that area.

The need for facilities to establish ongoing orientation and training for all staff in mental health concepts was invariably emphasized. The training format of the CEMH program was necessarily circumscribed, and it was recognized that the development of full program capacity in all but the most interested and advanced facilities was impossible. Consequently, one thrust of the program was to involve agencies which potentially could form ongoing relationships with the homes to assist in training trainers, and also in case consultation, staff education, formation and operation of family groups, recruitment and orientation of volunteers, psychotropic drug counseling, program development, alternate care and discharge planning, individual and group counseling for residents or families, organizing resident councils, developing and making accessible community resources, or both. Agencies participating included community mental health centers, State hospitals and State hospital outreach services, veterans hospitals, and various State agencies such as welfare, health, and social services. Strategies to involve these agencies were:

- inclusion in workshop planning
- inclusion as faculty or resource people in the workshops, or both
- inclusion in followup visits
- a series of conferences on "Mental Health Services and Consultation to Nursing Homes" conducted in Arkansas, New Mexico, and two Texas locations.

The enrollment in the CEMH workshops was limited by design to enhance communication and facilitate small group training methods. Fifteen homes were the maximum per workshop and six participants were the maximum number per home (three in the first 2-day session, three in the second 2-day session). In practice, allowances were sometimes made to exceed the maximum to avoid having to turn down any applicant homes.

Evaluation Procedures

Time and money constraints dictated that systematic measures of change produced by the CEMH program would be the traditional paper and pencil tests, because direct observation of behavior of the participants was not feasible. Additional nonsystematic observations, however, were made, for example, by consultative visits to the facilities. An evaluation form sent to administrators only was used. Further evidence came from unsolicited letters from participating facilities and newspaper clippings.

Systematic Observations

Systematic observations were made of both the administrator and low-skilled personnel before exposure to the program. Three tests were used: the Oberleder Attitude Toward Aging

Scale, a Job Performance Test, and an Institutional Climate Questionnaire. These tests were administered in a group testing situation. The same forms were mailed 6 months after the initial test for followup data.

ATTITUDES TOWARD OLD PEOPLE

The Oberleder Attitude Scale[5] was used to measure CEMH workshop participants' attitudes toward aging. Consisting of 25 of the most sensitive items from an original questionnaire of 176 items, the Oberleder Scale has been shown to be an effective discriminator of attitudes toward the aged. Scored on a simple 1-25 point scale, scores of 12 or under can be considered indicative of positive attitudes toward old people, while scores of 17 or over indicate a negative attitude toward old people. High scores on the scale also correlate significantly with the "F" Scale (the authoritarian personality).

JOB PERFORMANCE ATTITUDES

The best method of measuring changes in job performance as a result of the CEMH training program would have been to keep a detailed first-hand account of the pretraining and posttraining job performance of each workshop participant. Because this was not feasible, a test devised by Cohen[6] and later revised by Kosberg and co-authors,[7] designed to measure changes in the attitudes and opinions of nursing home personnel, was given to participants in the CEMH program. The questionnaire covered five major areas: (1) attitudes toward organizational dimensions, (2) attitudes toward care and services to be given, (3) attitudes toward the aged residents and their families, (4) humanistic values, and (5) knowledge of old age and aging.

INSTITUTIONAL CLIMATE ATTITUDES

As important as changes in an employee's attitudes and job performance may be in measuring the effectiveness of the training program, the climate of the institution which provides the organizational setting for the delivery of the services to the residents is the ultimate test of the effectiveness of the training program. The Home for the Aged Description Questionnaire[8] was adapted to measure changes in the institutional climate of the homes participating in the CEMH training program. The Home for the Aged Description Questionnaire (HDQ) is modeled after a similar instrument developed and used by Jackson[9] as a device to study the therapeutic milieu in mental hospitals. Essentially, the HDQ contains 36 statements describing various aspects of life in the home. Staff members of each home were asked to indicate on a five-point scale ranging from "completely true" to "completely false" how true or false a statement was about the home as they saw it.

Simple to administer and requiring only 15 minutes to complete, the HDQ can be administered to all levels of staff with success and is also a practical instrument to use in collecting data on a large sample of institutions.

Data Analysis

DESCRIPTION OF PARTICIPANTS

Sixty-five nursing homes and 473 persons participated in the CEMH sessions between November 1972 and July 1973. Of the attendees 419 were nursing home staff, 11 were from the Department of Public Welfare, 12 represented mental health and mental retardation facilities, 24 were from State hospitals for the mentally ill, and there were seven others.

The workshop had essentially two target populations: professional-administrative, and paraprofessional direct-contact personnel. The following analysis will be made of 321, or 77 percent, of these persons who completed both waves of the systematic evaluation testing. Twenty persons, or 6 percent, participated in the first series of tests but not the second. Most of those who did not participate in the second wave of testing were employees who left the facility 6 months later; a small number did not return the second questionnaire even after a followup letter.

Because the program was essentially directed at two target groups, these will be described separately. Of those tested, 163 or 54 percent, were administrators-supervisors, and 138, or 46 percent, were paraprofessional direct-contact personnel. Except in matters of education and additional training, the similarities between the populations were more striking than the differences. Both groups were middle-aged, and most of them were between 31 and 50 years, the majority were female, most were married, and generally they had been employed at the long-term care facility between 1 and 5 years.

On several important attributes which were measured, however, the groups did differ significantly. One of these, of course, was education. Of the administrative group, all reported having had some college training and 67 percent were college graduates. On the paraprofessional level, 21 percent had not finished high school, 68 percent had finished high school but had no further training, and only 10 percent had some college. Additional training followed much the same pattern with much higher levels of additional training reported by the professional than the paraprofessional. Most of the paraprofessionals had had no additional training. All but 12 percent of the professionals had had additional training.

Another area in which the difference was considerable was in previous jobs held. Administrative level personnel were about equally divided, one-third having held previous jobs in short-term health care, one-third in long-term health care, and one-third in nonhealth-related jobs. Paraprofessional personnel, therefore, were more likely to come from outside the health related fields; only 18 percent came from the long-term field, 9 percent from short-term care. Sixteen percent came from service or sales, and other previous jobs had been as a laborer, in industry, and as a secretary. Most, 31 percent, had had no previous employment for pay but had been housewives.

RESULTS OF ATTITUDE TESTING

Prescore and postscore differences on all but one of the attitude tests were significant at the .05 level. The single exception was the Work Performance Test with the level of training held constant. Measured on attitude change from pretesting to posttesting, then, the workshops made significant impact.

Controlling for six variables hypothesized to intervene (age of participant, administrative level, previous employment, length of time employed, level of education, and additional training) produced mixed results. Analysis of variance showed that the Work Performance Test was not significantly affected by differences in age, length of employment, college or additional training. Job titles and whether previous employment had been in a health-related field, however, did make a significant difference.

Institutional climate scores were significantly affected only by job titles, length of employment, and additional training.

The Oberleder Attitude Toward Aging scores were significantly affected by job titles, length of employment, and college training.

In summary, overall significant changes in attitudes as measured by the Work Performance, Institutional Climate, and Attitudes Toward Aging tests were demonstrated. Only one variable, however, job titles, consistently and significantly affected the amount of change, with paraprofessionals showing more change than administrative-professionals on Work Performance and Institutional Climate, slightly less the higher the job level on the Attitude Toward Aging scale.

Nonsystematic or Subjective Observations, or Both

CONSULTATION VISITS

Several other techniques were used to measure effectiveness. Certainly one measure of effectiveness was the number of nursing homes which invited a consultation visit after the workshop. All the homes participated in the followup. All the homes which participated in both parts of the workshop received two followup visits.

It is the opinion of the project staff that the followup visits constituted the most effective component of the training package. Many trainees, i.e., administrators and directors of nursing, left part 1 of the "Mental Health for Nursing Home Residents" workshop with enthusiasm, but an enthusiasm tempered with an attitude: "Yes, it looks like our residents do have greater potential for more meaningful lives in our Home, but how can we convince the aides and maids and waitresses when they don't care enough about their jobs even to give notice that they are quitting?"

In virtually every case, however, these aides, maids, and waitresses, many of whom had doubtless been selected with some misgivings to attend part 2 of the workshop, returned to their jobs with a brand of enthusiasm noted by most of the administrators and directors of nursing who participated in the part 1 workshop with mild to marked surprise. This development was reinforced during followup visits, when it was again demonstrated by the project consultant, in addressing groups of employees, that even the dimmest ray of hope for the improvement of residents' lives, combined with a nondidactic approach and a frank appraisal of how such an approach could enrich the job of each employee, was sufficient to raise from dormancy the enthusiasm of all but the most resistant of staff.

The film "Mrs. Reynolds Needs a Nurse" was generally shown during the first visit, followed by a discussion of the factors which shape behavior patterns of residents of long-term care facilities. Concepts of attitudes, expectations, communication, stereotyping, individualization, self-determination, reinforcement, and prevention were discussed relative to residents known to the staff. The film depicted, rather painlessly and with humor, the ease with which staff can make mistaken assumptions and the benefits which accrue for resident and staff with goal-oriented attitudinal shifts.

During second visits, demonstrations of classroom techniques on reality orientation were conducted with confused residents selected by the staff. As the consultants became more adept at giving these demonstrations, they came to represent the single most effective tool in eliciting staff enthusiasm and altering attitudes toward greater hopefulness. The residents selected invariably exhibited greater potential than expected by staff in terms of verbalization, attention span, recall, appropriate effect, and judgment. When given without an "I told you so" attitude and billed not as a panacea but as one small example of the mental health potential of nursing home residents, these demonstrations assured credibility for virtually the entire gamut of mental health strategies and concepts.

It was at this point, the completion of second followup visits, that the training design began to manifest its weaknesses. Generally, the training fell short of adequately training trainers who could effectively integrate mental health training into the facility's own training program, although some impact was made in this area. Also, the attempt to stimulate ongoing working relationships between nursing homes and mental health agencies fell short, with notable exceptions. The obvious need was for a mechanism through which interest and hope, once generated in the nursing home, could be regularly supported and supplemented until a self-sustaining structure, in terms of the nursing home's development of a rehabilitative and preventive philosophy reflected in its policies and procedures, might evolve. As one step toward this end, it was decided to hold conferences on "Mental Health Services and Consultation to Nursing Homes" for mental health center, State hospital, and State agency personnel. These conferences are described later in the report.

PROBLEM AREAS

Another technique used was to ask the administrator of the participating nursing homes to rank 16 problem areas in order of his own perception of their most pressing problems. All participating homes did this as a part of the application procedures for the administrator. The results of the rankings are as follows:

Problem	*Times ranked in top 3 of 8 total problems*
The resident who is frequently incontinent of feces and urine, or both	49
The resident who does not seem interested in learning to help himself	40
The resident who wanders away unless closely watched or restrained	32
The resident who rarely speaks, moves, or shows interest in anything	31
The resident who has frequent outbursts of anger or aggression	20
The resident who frequently schemes, manipulates or complains	19
The resident who is nosy and wants to make everything his business	16
The relative who frequently criticizes the home or the staff	15
The relative who seems to have a bad effect on the resident's behavior	15
The resident who is overly suspicious and fearful	13
The resident who is excessively noisy	9
The resident who seems to want to die	8
Low staff morale	4
The resident who masturbates, exposes himself, or makes sexual advances	3
High turnover and absenteeism among staff	20

Incontinence was clearly considered the top problem raised by the resident who is not interested in helping himself, the one who wanders away, and the one who is apathetic—rarely speaks, moves, or shows interest in anything. Ranking importance with these problems with residents, the following two staff problems appear as troubling—high turnover and poor communication. An additional problem, ranking equally in number of times chosen, was a further problem with patients: that of patients who have outbursts of anger or aggressiveness.

As part of a followup at least 6 months after the workshop, each administrator was asked to rate each of the problem areas in terms of his perception of improvement. Thirty-five or 54 percent of the administrators responded to this evaluation. All reported improvement in some of the areas. Improvement was greatest in areas where the CEMP training was not directly relevant: control of anger, aggression, and apathy among the residents, and improving communication among the staff. It was least effective in the areas where one might expect physiological concomitance, incontinence among patients, turnover and absenteeism among the staff. Even in these areas improvement was considerable.

INTRODUCTION OF TREATMENT MODALITY PROGRAMS

Another observation was made using the posttraining evaluation form filled out by the administrator of the nursing home. This observation concerned the existence of various treatment modality programs in the homes which were as follows:

Programs	*Number of homes in which available*	*Percent*
Reality orientation, 24 hour	25	62.5
Classroom reality orientation	22	55
Remotivation (discussion groups)	28	70
Team approach to care	31	77.5
Behavior modification approach to care	21	52.5
Attitude therapy approach to care	17	42.5
Useful work activities	31	77.5
Self-help programs	16	40
Regular meetings with relatives	10	25
Increased use of volunteers and community resources	30	75

NOTE: Average per home 5.8 (maximum 10.0).

There was no pretraining measure of these treatment modality programs, because we did not ask for the data, feeling that before the training session much of it would be unintelligible to the participating nursing homes. There is now a high level of involvement in the psychosocial aspects of patient care, although none of the homes listed indicated they did not have a program. Of course, bias is possible—even probable—in the return rate. It is not known whether or to what extent, nonreporting homes have programs.

Observations for Future Workshop Planning

Part of any continuing education program should contain both a participant and a provider feedback which could be helpful to others planning similar efforts. The workshops in this series varied on a number of dimensions: experience of the workshop staff, physical setting that was an aid or a detriment to the learning situation, a target population with many opportunities for learning and sharing (those in an urban setting) compared with an area where workshops are seldom available (rural areas or those in sparsely populated sections of the State), and probably many others. Because of these observations, an analysis of variance was made to determine if there was a consistent pattern of significant differences between the workshops on the three attitude tests which we had used. Significant differences did appear between the workshops on both the Attitude Toward Aging (.0401) and the Institutional Climate (.0037) tests. The Work Performance score (.0179) also showed a high degree of difference. The pattern of improvement on scores was inconsistent and could not be attributed to any particular variable or combination of those variables suggested above. Workshops do vary and the results, as we have demonstrated, also vary. More systematic attention, however, needs to be directed to identifying significant environmental and programmatic functions so that information can be gained to improve workshops in the future.

Finally, administrators who responded to the training evaluation form were asked directly for a number of observations and recommendations regarding future workshops. The question and responses are shown in the following tabulations.

For future workshops of this nature, which of the following staff groups do you think should attend?

Category	*Number*	*Percent*
Administrators only	1	2
Administrators and other key personnel only	6	14
Key personnel and lower level staff in separate sessions	11	25
Key personnel and lower level staff in joint sessions	26	59

NOTE: Total equals more than 40 because of multiple responses.

Do you think followup visits by workshop faculty are helpful?

Response	*Number*	*Percent*
Very helpful	16	40
Somewhat helpful	22	55
Not helpful	2	5
Harmful	0	0

If available, would your nursing home use regular mental health services and consultation?

Response	*Number*	*Percent*
Very often	16	40
Occasionally	20	50
Very rarely	4	10

If necessary, how much would your home be willing to pay for monthly mental health consultation or staff education by mental health professionals? (based on estimated $50 per 2-hour sessions)

Response	*Number of responses*
Nothing	6
$25 for 2 months	1
$50, if reimbursable	6
Would pay $50	7
Would pay $100	2
Would pay $100–200	1
Variable with need	1
Already have psychologist	1
Would but cannot now	4
? or unknown	6
No answer	8
All residents, private pay	1
Prefers sending staff to seminars	1
Total	40

Analysis of Mental Health Services and Consultation to Nursing Homes Conferences

It was postulated in the formulation of this contract, and substantiated in its implementation, that most nursing homes, in order to develop policies and continuing practices conducive to mental health of residents, would require ongoing relationships with agencies or persons capable of delivering mental health services, consultation, and training. As explained earlier, this problem was identified during the consultation visits to individual homes. Therefore, as an extension of the original contract, a plan was made calling for a series of conferences on "Mental Health Services and Consultation to Nursing Homes" to be initiated by a regional conference for the Department of Health, Education, and Welfare (DHEW), Region VI, followed by five State-level conferences. Primary target agencies were community mental health centers, State mental hospitals, and State agencies of aging, health, social services, and welfare. Additionally, such agencies were to be more actively solicited to participate in the planning and implementation of the contracted "Mental Health for Nursing Home Residents" workshops and followup visits.

In August 1973, a DHEW Region VI conference was conducted as a platform from which to develop State-level conferences in each of the Region VI States. This conference was well attended (85 participants) and well received. To date, followup State-level conferences have been convened in Arkansas, Texas, and New Mexico. Oklahoma was approached, but the State Department of Mental Health opted to plan and give conferences of its own. The project coordinator has subsequently participated in three such conferences and is slated to be on the agenda of two upcoming ones. Louisiana has yet to be formally approached.

In Arkansas, the conference which convened in October 1973 was poorly attended (39 participants). In addition, the physical setting, the auditorium of a mental health center, was not conducive to group interaction on the first workshop day. The second day, which consisted of small group sessions in conference rooms, was more effective, but still poorly attended. The Arkansas conference preceded the "Mental Health for Nursing Home Residents" workshop held some 4 months later. This conference made possible the participation of mental health and State agency personnel in the planning of the workshop, and consequently many such agencies were represented at the workshop and at the subsequent followup visits to participating nursing homes. As a result, several working relationships were developed or enhanced, although the potential for such relationships remains far from full realization.

In Texas, the conference convened in June 1974, was moderately well-attended (74 participants), and the setting and format were more conducive to group interaction. The conference was held in a resort hotel in Galveston. Six Texas mental health agencies are currently involved in planning a "Mental Health for Nursing Home Residents" workshop, and another is responding positively to a request for services from a delegation representing nursing homes. Still, the surface is only being scratched.

In New Mexico, the conference was surprisingly well attended (114 participants), considering the density of population and the distances involved in traveling to the conference, which was held in a well-known Santa Fe hotel. The participants represented a mix of mental health, State agency, and nursing home personnel. The greatest need in New Mexico seems to be the need for one of the State agencies, such as the Department of Hospitals and Institutions (DHI), the Health and Social Services Department (HSSD), or the Commission on Aging, to take the lead in developing relationships with nursing homes, or in stimulating such relationships. The two mental health centers in the State have shown increased interest, but they are limited by their small catchment areas.

In at least one area, staff of the Health and Social Services Department are attempting to provide more inservice education on aging. Staff from the Department of Hospitals and Institutions were instrumental in planning both the "Mental Health for Nursing Home Residents" workshop held in Carlsbad in July 1973, and the conference previously described held in August 1974. Following the 1973 workshop forum, a social worker from the DHI field office provided the followup visits to six participating nursing homes, but the suggestion from the project coordinator that she subsequently train her 11 counterparts to establish similar relationships in their respective areas has not yet borne fruit.

In Oklahoma, the State Department of Mental Health decided to have its own conference, in which the project coordinator participated. Oklahoma's Western State Hospital invited the project coordinator to give a 1-day workshop on reality orientation for nursing homes in their catchment area, and the State Nursing Home Association has invited the coordinator to make a half-day presentation at its annual meeting in May 1975. Activity in Louisiana is yet to be started.

The activities previously mentioned varied considerably in content and format, contingent upon the input from those planners consulted in each State. For this reason, no formal evaluation on these conferences was made.

Basically, the same barriers exist which were used to document the need for the "Mental Health Services and Consultation to Nursing Homes" conferences. It appears in retrospect that it would have been wise to build in a followup visit component for mental health agencies analogous to the nursing home followup plan. The plan to have the conferences and to involve appropriate agencies in the nursing home workshops and followup visits was sound, but often fell short of stimulating actual ongoing programs aimed at effectively serving the nursing home population. The barriers included the following:

1. Under the 1972 contract, contacts with nursing homes centered around a population, the residents, with which the trainees were inextricably involved on a round-the-clock basis, whereas contacts with mental health agencies dealt with a population, nursing homes, with whom they were involved minimally or not at all.

2. The format of the 1972 contract allowed for followup visits to nursing homes, but not to mental health agencies, resulting in a depth of exposure for the agencies insufficient for the development of significant program change.

3. The existence, on the part of mental health agencies, of hopeless attitudes at the prospect of working with the elderly and of concern about the low status commonly accorded such work.

4. The claims of mental health agencies that they lack staff adequately trained for working with the elderly, especially those in nursing homes.

5. Inadequacy of or confusion about mechanisms of reimbursement for mental health services and consultation to nursing homes.

6. A lack of pressure for services to the elderly from potential consumers or their advocates.

7. Budgetary and staffing concerns over what is viewed as an expansion of program and services.

8. A desire to delay programing relative to nursing homes in favor of programing for the aging generally.

In summary, the "Mental Health Services and Consultation to Nursing Homes" conferences in Texas, Arkansas, and New Mexico, plus the various contacts made with Oklahoma agencies, have served primarily as consciousness-raising devices. Many mental health agencies can now be considered more approachable in terms of working with long-term care facilities and the aging. Simultaneously, there appears to be a growing desire on the part of nursing homes to seek and use mental health services beyond requests for prescriptions of tranquilizers and transfers to State hospitals. The attitudinal barrier appears to be dissolving, and the competence barrier reported by many mental health agencies is probably lower than imagined.

It would be unfair to this project effort and to many mental health agencies to leave the impression that no effective relationships with nursing homes are being developed. Many times, however, the efforts lack coordination, continuity, and goal-directedness. It is hoped that a new training grant beginning in July 1975 will provide more intensive and long-term training on aging for mental health agencies and will help to translate interest in aging services into effective programs.

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Training Project on Mental Health Aspects in Nursing Homes,
Ethel Percy Andrus Gerontology Center,
June 27, 1972—September 26, 1974

Introduction

Approximately a year before the actual funding of this project, the California State Departments of Mental Health and Public Health (reorganized in 1973 into a superagency known simply as the Department of Health) started a joint project to assist community care providers to develop training for their staffs who work with institutionalized persons. First priority for such assistance was given to convalescent hospitals, nursing homes, and psychiatric, locked ("L" facilities), and long-term care facilities.

Nursing educators were assigned to newly determined regions of the State to act as coordinators and consultants for training within these newly designated regions. This focus upon regional as well as onsite training was a relatively new thrust for the department. A survey of administrators of nursing homes and long-term care facilities, during this period, indicated substantial interest among these care providers. The end result of this joint project was the drafting of an application to the National Institute of Mental Health for funds to organize a project that would use the collaborative efforts of the Department of Health, an institution of higher learning, and interested key persons from participating long-term care facilities.

Psychosocial Aspects, Primary Focus

The focus of this project was on the psychosocial (mental health) aspects of care of the elderly resident, client, or patient in congregate living settings. By emphasizing the psychosocial aspects, we did not intend to minimize by inference the necessary and important provision of medical services or public health components of care. These services as a general rule have to do with making continuing life possible for the older person.

Of equal importance, in our opinion, are those aspects which contribute to making the older person's life worthwhile. As a consequence, the principal objective of this training program was to emphasize the need to sensitize staff persons and others to the ways in which people and things, as component parts of the total environment (the life space of the individual person), can be geared to make up or compensate for the many and varied losses experienced.

In this sense, the training components of this project were intended to help staffs be as imaginative and creative as possible in designing and bringing into reality the appropriate prosthetic or compensating environment. It included the concept of the barrier-free environment, but it goes well beyond.

The main objective of the project then was to stimulate and assist staff persons to learn to think, plan, and behave in such ways (even, if necessary, untraditionally) so as to help older residents maintain (or regain, when feasible) to the fullest extent possible their own competence for living and their sense of self-worth and self-esteem. An acceptable level of quality of life is not possible without that.

Another objective was to develop models of continuing education programs to use to train the staff working in the long-term care facilities. The training, we hoped, would effectively promote and facilitate ongoing continuing education programs and establish and implement training modalities. The modalities would help translate these training programs into projects that could be used not only in California but elsewhere if needed.

The main thrust of the program was to involve each participant to the maximum degree possible: we wanted them involved in the demonstrations and taking part in the dialog and discussion by a free and we hoped candid exchange of views. We were looking for an increased sensitivity to the critical issues, a shift in negative attitudes toward more positive ones, a greater degree of innovative thinking and behavior which would lead to policy and programmatic changes to upgrade and improve the quality of life of the nursing home residents. To this end, it was clear that the development of group cohesiveness was a must.

Discussions with members of the advisory panel and other consultants made several other considerations readily apparent. One was the need for a practical, program-oriented approach to training. Care providers, such as physicians and other long-term care professionals, tend for obvious reasons to be extremely task- and practice-oriented. And so any tendency to engage in abstruse or purely theoretical discussions had to be assiduously avoided. This requirement put the instructors on their mettle to translate research data and theory into practical applications.

We hope that the model of continuing education and experiences with key personnel and staff described in this project report will be useful. Is is based upon a model training program developed and tested in actual practice in a 2-year period by the Andrus Gerontology Center in collaboration with the California State Department of Health and funded by the National Institute of Mental Health.

Selection of Participants

Because, as already noted, this project was intended to be a collaborative effort with the Department of Health (Department of Mental Hygiene), we were guided by the special interest of the department at the outset by reaching so-called "L" (psychiatric, locked, long-term care) facilities. Our first training group basically was made up of teams of administrators and directors of nursing from four separate "L" facilities in the Los Angeles area.

These facilities were selected from a list of respondents who had indicated a strong interest in such training in an initial survey. The final selection of the group was also based in part for logistical reasons on the factor of geographic proximity.

The major thrust of this demonstration project during its first year was toward long-term care facilities in the metropolitan Los Angeles area. During the second year, the intent was to train similar groups in other areas of the State known for their high concentration of nursing homes. In such areas, participants were in part selected because of their potential for eventually becoming resource and peer trainers in their locales. With several notable exceptions, this goal appears to have had a better than fair chance of fulfillment.

The key persons, the administrators and directors of nursing, of long-term care facilities were our first targets. These key persons set the tone and climate of the facility. Without their understanding of and sensitivity to the critical issues involved, and their support of the goals to be achieved, staff training would probably prove to be partially effective at best and unusable and wasted at worst.

It should also be noted that the newly established State Board of Examiners of Nursing Home Administrators (BENHA) was requiring 100 hours of continuing education work biennially to maintain a nursing home administrator's license. There was, therefore, increasing demand for courses and training programs which were relevant and appropriate to such State licensed persons and which would also provide a substantial number of approved hours of continuing education credit. Thus the 70 hours of continuing education credit approved by BENHA for this training program provided a real incentive for participation on the part of the licensed persons.

We expected to train these key people by sensitizing them to the issues and building their support of innovative positive change. They in turn would be involved in training their own staff along the same lines with support of the instructing staff. Our subsequent experience and the experience of others has, over time, demonstrated the sensibleness, the validity, and in general, the reliability of such an approach.

Three Dimensional Model Designed

FIRST DIMENSION

Our major goal was to develop a three-dimensional model. The first dimension had to do with the priorities and organization; the second with coordination and collaboration; the third with teaching strategies and methods. The primary unifying goal was to enable residents in skilled nursing homes and long-term care facilities to function at an optimal level of competence and satisfaction. The unifying theme in general was the emphasis on the psychosocial (mental health aspects) dimensions of care; in particular, thematic focus was on compensations for loss in old age and the design of prosthetic environments.

The project was organized so as to test out two parallel yet distinctly different approaches to the training format. The first priority was onsite teaching, and a second priority was on developing a workable onsite model of training which would stimulate and be incorporated into inservice training in target facilities.

SECOND DIMENSION

The second dimension of the model, effective communication and collaboration with the mental health component of the newly formed Department of Health and other agencies, was early established through an Advisory Committee. This committee met approximately every 3 months (at the beginning it met monthly), was much involved, and responsive.

THIRD DIMENSION

Our objective in designing the specific teaching strategies of this project was to establish procedures which would approximate the following goals:

To begin to describe, delimit, and interpret the complex psychosocial (mental health) factors which are involved in and affect the behavior of the staff, the residents, and their families.

To confront participants with the variety of myths and stereotypes about old age and the elderly which are widely held and destroy these by utilization and dissemination of more realistic views of the aging process available through the latest research and experience.

To sensitize students to the existential needs of elderly residents and help make "connections" between certain kinds of policies in long-term care and the effects, both good and bad, upon the residents.

To train students to recognize the significant role played by the environment in its interaction with residents and stimulate imaginative approaches to designing a prosthetic, compensating environment.

To train students to recognize the potential of residents for competent functioning and the potential of staff for a larger role within the facility.

To help develop modalities for increasing the maximum collaborative participation of supportive agents from outside the facility, such as friends, businesses, volunteers, and community groups.

To encourage mutually supporting, mutually educating efforts through ongoing or repeated programs of continuing education, both formal and informal, eventuating in programmatic policy and programmatic change which would improve the life and functioning of residents.

In summary, our teaching goals were: (1) to increase understanding of the aging process, (2) to destroy myths and stereotypes about the elderly, (3) to delineate some of the important factors in the person-environment transactions and how to modify these, (4) to encourage and to provide models for continuing education courses, and (5) to show the commonalities between psychosocial dimensions of care of the elderly resident and factors affecting families and staff.

In due time, as the project progressed, additional goals were identified, namely, to involve other components of the long-term care system, such as the attending and referring physician, the surveyors (State Department of Licensing field representatives), and ultimately the legislative groups which devise and enact laws and regulations governing long-term care. The initial overtures in this direction have been made by necessity in a limited way and with limited results.

Conduct of the Project

The entire project was conducted in a series of sequential stages. The first, upon which later modifications were based, included four "L" facilities (proprietary) from the central Los Angeles area and continued for the longest period, 16 weeks. This group, as most of the others, took several sessions to warm up to each other and the instructors as well.

In time, however, a strong sense of group identification began to build and was manifested by the increased willingness to share with the group what were potentially embarrassing intrahouse staff and resident-related problems. General attitudes toward staff and clientele elicited at the onset were in the main rather negative. One administrator candidly admitted that he viewed his residents essentially as merely bodies. The following, for example, is characteristic of the kind of descriptive words elicited from the group about residents:

Sensitive person
Noisy
Nosey
Stubborn
Suspicious
Neglected
Spoiled
Frustrated
Well-adjusted
Restless
Interesting
Sense of humor
Chronically ill
Happy
Individualistic
Hoarding
Dirty habits
Humiliated
Dependent

Staff were frequently characterized in effect as untrained hired hands. Such views were shared by the other participants in the group although with varying degrees of reservation. As the sessions wore on, we began to see a softening of these attitudes, especially as expressed during the followup training sessions. The administrator who had viewed his residents as bodies, for example, was uneasy at first about his role as a teacher. He was observed subsequently leading discussions in a group of about 11 of his staff and commenting on problems of charting the behaviors of residents.

After leading into a discussion of the resident's career prior to admission (replicating in large part the previous Wednesday's session) he warmed up to the subject, lost his ill-at-ease manner, and began getting more frequent responses from the staff. The log notation indicates that he became more effective, at times even eloquent, in making points about the importance of maintaining the resident's sense of self-esteem, self-worth, and dignity. At one point, the log notation indicates, he was describing a hypothetical facility, pointing out how it might provide clean floors and clean sheets, adequate food and proper medications, but "that just isn't good enough for this facility." We observed further indications that he was beginning to think differently than he had in the past about his residents, his staff, and about the policies and operation of his facility.

One programmatic change on the part of this facility was the initiation of a so-called cocktail hour in the late afternoon each day at which time the socializing of residents was enhanced by serving wine and snacks. After several weeks, we observed that the staff's response to this innovation was positive; much more spontaneous socializing took place, and the flagging appetites of some of the residents were rejuvenated. Residents were also reported as sleeping better at night.

Most of the facilities were observed to be taking pains to make their own training classes more interesting and pleasant—even fun—by increasing informality, encouraging free exchange, serving some kind of snack (e.g., cookies), and a choice of beverages (coffee, iced tea, and punch). We noticed increased attention in the discussions to the dominant theme of environmental support and self-esteem.

The students spontaneously decided after the third training session to have lunch together, which turned out to be another manifestation of the growing sense of group cohesiveness. A great deal of sharing and informal exchange took place during these lunch periods. These friendly exchanges laid the groundwork for a kind of balancing effect in the dialog of our training sessions. That is, whenever we presented a particular issue which would indicate the need for a policy or program or procedural change, not infrequently some member of the group would respond to the challenge with "yes—but!" This negative response usually led to a lengthy exposition of why something could not be done, or could not be changed ("cost too much," for example, or "not feasible"). Almost invariably another member of the group would intervene with, "Why can't you do it? We do it." And this afterwards turned into a discussion of creative solutions.

One administrator and his co-teaching director of nurses became acutely aware of the relative lack of meaningful activity programs in their facility. Teachers from this facility were the only ones that assigned homework in its followup training. Three questions were written on the blackboard for consideration and discussion at the next staff training session:

- How can we personalize the space of our resident?
- What activities can we begin or add for our resident?
- What can we do to make life worthwhile for our resident?

Organizing the Training Group

The procedure followed at the beginning of each training group was as follows: after the probable participants were contacted and selected by our regional mental health consultants, a letter was sent to each of the facilities inviting the administrator and director of nursing to meet for approximately 2 hours in a designated place and at a time convenient to all. This meeting usually took place about 2 weeks before the first training session. At that meeting (one of which was a luncheon meeting) the project director and assistant project director introduced themselves, met the participants, and then summarized the background, the goals, the general format and procedures, and expectations of the training project. Some general housekeeping and administrative details were ironed out, questions raised by attendees were answered, and schedules and timing were agreed upon. Our main intent, in this "get-acquainted" session, was to create a positive atmosphere and gain the cooperation of the participants and their peers. The suggested format for this preliminary planning meeting was as follows:

OBJECTIVES:

- To introduce (get acquainted) with instructors, participants, and consultants (if any)
- To explain logistics and administrative details and, of course, answer questions
- To explain general theme and goals of the course
- To accomplish any pre-course evaluation procedures.

METHOD:

Verbal sharing
Discussion—questions—answers
Have students draw themselves as they imagine themselves at about age 80 (or 90); discuss attitudes toward aging suggested by drawings.
Give an attitude scale measure (attitudes toward the old or toward the job or toward the facility).

This introductory session need not take over 1 hour or 1½ hours at most. As already mentioned, the followup function proved to be most important, not only to insure the carrying out of the staff training as agreed upon to maintain continuity and provide support, but also to provide opportunity to observe and record in a log any kind of policy or programmatic change.

The following outline was used by the recorder during followup sessions and the information obtained was used in the evaluation of the project:

SETTING:

Was the room adequate?
Did they have good lights and ventilation?
Did they have comfortable seats?
Did they provide a place to write?
Were adequate equipment and materials available to participants, such as blackboards and appropriate visual aids?
What extra conveniences were provided (such as snacks, etc.)?
Were students able to hear?
Were the surroundings conducive to learning?

ATTENDANCE:

Who attended?
How many and how regularly?
Did the facility have a representative for the staff present?
Did the meeting start on time and were participants on time?
Did participants stay for the full session?
Did everyone participate?

MATERIAL:

What format was used?
Did the instructor follow the outline or get off the subject?
How was the discussion handled?
Was the material presented in an exciting, lively way or were the sessions dull and uninteresting?

DISTRACTIONS:

Were outside noises loud enough to distract?
Were there many interruptions, how many, and how were they dealt with?

CHANGES:

What was the response to training?
Were there any attitudinal, programmatic, or policy changes?
What were the differences, if any?

GENERAL:

Was the impression given that continuing education training was important?

We determined to use two basic strategies to achieve group cohesiveness. One strategy was to use the same instructor units (either team-teaching or tandem teaching) throughout the training track, and the second was to hold the groups to a small number of participants. Most training sessions involved approximately a dozen persons. Those sessions conducted in the north of the State included about a half-dozen more because of the logistical need to include some four or five mental health consultants to assist with the followup of an increased number of participants. In summary, the average number of participants in the various training sessions was 15 persons, which was probably about the right number of participants, given the results we had set out to achieve.

During the period of our first training course, all sessions were held in one institution acting as the host facility. In subsequent series, two or three sessions took place at one of the facilities represented in the participant group and then the sessions were held at several other facilities in turn. This rotation provided not only variety but also the opportunity for these key people (administrators and directors of nurses) to examine first hand facilities and operations other than their own. We discovered that ordinarily these key people seldom if ever had a chance to do just that, and, in fact, they welcomed and enjoyed the opportunity to do so.

We constructed the training sequence and substance of each session to run parallel to a natural series of events. This format meant dealing with issues as much as possible in the sequence they were likely to occur in a nursing home or long-term care setting.

We began with our formal pretest evaluation materials and then discussed general attitudes toward (a) the elderly, (b) older residents, and (c) staff. The sequential approach consisted then in dealing first with issues relating to the prior career of the resident in the nursing home and then the major topics and issues were discussed. We then switched the focus to the family, discussing issues related to the family at time of admission, admission adjustment, the period following admission, and so on. Final training sessions focused on staff needs, staff development, and morale.

Onsite Teaching

Another important consideration was where to provide the training. The determination to do this onsite (that is, within the environs of the nursing home) proved fortuitous for a number of reasons. For one, onsite teaching stimulates and encourages ongoing continuing education. We were able to teach at the scene of the action; thus, we had the teaching-training activity take place where the subsequent followup activities were to take place. We wanted continuing education to become part of the warp-and-woof, to get embedded in the bloodstream, so to speak, in the administration of long-term care facilities, and onsite teaching proved to be a most useful modality toward that end. At the same time, some of the problems and difficulties encountered by administrators and directors of nursing in establishing and carrying on continuing education programs were illustrated in our onsite teaching. For example, a number of facilities acquired basic equipment which they had not had before, such as a large blackboard, chalk, and erasers, as a result of our teaching requirements.

We also had available to us a goldmine for clinical demonstrations, e.g., elderly patients for interviewing before the class and groups for demonstrating group work. The effect on residents was therapeutic, and staff who did not participate directly in the class became involved in getting residents ready or escorting the elderly to and from the classroom setting. The availability of residents to complement teaching was one of the important assets of onsite teaching.

We had to contend and deal with such things as selecting adequate and appropriate space and time for training, interruptions by other staff, intrusions and interruptions by residents, and unforeseen emergencies caused by both things and people. By coping as effectively as possible with these housekeeping and administrative details as they occurred in the nursing home, we were able to provide something in the way of modeling for those who themselves were required to become teachers and trainers.

Differences in capacities to translate the formal training into staff training (the followup staff sessions) did begin to surface early. The transition from being a participant in formal training to trainer of staff seemed to be closely related to variations in prior education and experience in the field and also to the size of facility and extent of financial resources available to these key people.

Not least among the problems we faced were the number of distracting demands upon the time and attention of these students and the personal importance they place upon training programs, both for themselves and their staffs.

In general we were able to "hold" them to the extent we were able to keep the training on a pragmatic level, closely tied to problem-solving and "how-to-do-it." A closely related yet subtle issue had to do with the attitudes of the key people toward their clientele and staff as well. This climate, no doubt, is a universal issue involved in all such training.

Some of these students learned to cope with the aforementioned distracting demands in creative ways. Most of the students followed our model (and suggestion) of team-teaching. In one instance, for example, the administrator would do much of the presenting of material. When called out by the front office on an emergency, her director of nurses would immediately take over—even in midsentence—and continue until the administrator returned.

The main nonverbal message to the staff, however, was the importance these key people placed on training. For example, at one training session the key people operated two different facilities, one a nursing home and the other an "L" facility, about 5 blocks distant from each other. All of the early followup training was given in the nursing home, which gave rise to complaints from the "L" facility staff that they were being left out. As a result of a dialog thus generated, other complaints of the second staff began to surface with the result that the social worker began to conduct a parallel training program in the second facility.

Similar questions and complaints from staff not involved in this training cadre came to the attention of our students. All began to discuss plans for continuing the same training with the remaining members of their staff at a later time. The night staff at one facility expressed exceptionally strong interest in the program; as a result, the administrator arranged an additional (to the regular followup training) training program early Monday mornings as soon as the night staff came off duty. The administrator taught this class herself.

On the other hand, one director of nurses remained conspicuous by her absence in both the Wednesday sessions and the followup training. As nearly as we could determine, she defined her role as nurse so narrowly as to mistakenly exclude herself from almost all involvement with the psychosocial dimensions of care of the elderly. This attitude is by no means an uncommon one.

As another example, an administrator was experiencing a great deal of stress arising from the obvious lack of cooperation evidenced by several long-time employees inherited from a previous administration, as well as lack of energy and interest on the part of the director of nurses. This administrator shared some of these problems and his associated feelings with the group. Not surprisingly the group responded with much support and also with some direct, straightforward advice, and exhortations to "really take charge" of the situation. Of the entire group, this particular facility provided the least reliable and least consistent followup staff training programs. At this facility, some sessions were missed entirely, other sessions did not appear to be adequately prepared for, and staff training, nonverbally at least, was given rather low credibility and status. One major factor in this poor showing was the selection of an inadequate place for training staff (not enough chairs, too noisy, lack of privacy, and no blackboard) and the lack of regularity in scheduling. All of this confusion found its counterpart in the warehousing atmosphere of the facility, which again underscores our belief that the attitudes (good or bad) of such key people as the administrator and director of nurses are invariably directly reflected in many ways in the quality of life of the residents.

Students as Teachers

It now appears that one of the best features of this project was the requirement that our own participants shift from the student's to the teacher's role in training their own staff. This requirement created a momentum for establishing a continuing education program in each facility that would not have worked as well any other way. Each week the participating administrators and directors of nursing met our instructors for almost a full day's seminar (9:00 a.m.–3:00 p.m.). The morning session consisted of presentations and discussion, and the afternoon session revolved around the clinical laboratory. This laboratory was planned either to illustrate the subject of the morning's discussion or to demonstrate some practical application of a problem discussed. Several modes and procedures were used during these clinical laboratory periods; they ranged from the use of appropriate and relevant tapes and soundfilms, through self-experiencing of sensory deprivation, to the interviewing of elderly residents.

At the request of the students, a time was set aside for problem-solving discussions during the clinical laboratory. The problems were common, urgent ones that had beset one or more of the students during the previous week. They varied from how to handle drunken staff members to how to maintain or use the fire sprinkler systems. The problems were always student initiated and discussed by the entire class.

Some time was spent during the introductory session, the first formal session, and at the conclusion of each training session on what can best be called "how to teach" methods. We found it was a mistake to assume, even though the participants proved to be for the most part well-educated and articulate people, that they would feel comfortable immediately in a teaching role. A large number indicated that they had felt ill-at-ease and uncertain initially as teachers, and that our discussions on the teaching process itself, brief though they were, did help.

At the conclusion of each Wednesday's training session, a brief period of time was spent in an effort to crystallize the major points covered and the salient issues raised. This time was labeled "important points to teach" and was devised as a help to the participants in organizing their own teaching strategies for the following day.

Each Thursday or Friday following the Wednesday training session, the participants were expected to meet a minimum of 2 hours in their facilities with their staff presenting at least the major aspects of the Wednesday's session. Those participants teaching were encouraged (although not pressed to do so) to use Wednesday's outline. Our outline was almost always followed.

To insure the regularity of these staff-training sessions as well as continuity of content, the regular instructors were present, not to take over teaching, but to observe and to provide support when necessary. There were indeed several occasions when the instructor had to take over practically the entire training function during the followup when it appeared obvious that the trainers in the facility were neither prepared nor willing to instruct their assembled staff. These events were shared in as diplomatic but straightforward fashion as possible with the group in the following Wednesday's seminar.

Training Sessions

After considerable exploration with members of the advisory panel, we decided to have one ensuing group made up of nonproprietory facilities and another group comprised of a mix of such facilities. The idea was to try out different formats of organization and study the group of participants so as to get a fix on that training model which approximated the optimum.

In reviewing the results of our first training course, we decided we could condense the subject matter and still accomplish the same results. Coupled with the logistic constraints embedded in the requirement that we give two training sessions simultaneously during the latter part of the first funded year, we revised our teaching outline to fit within a timespan of 14 weeks. Subsequent training series were designed to run 10 weeks.

Preparing to Teach

The description of the course content was taken from a manual developed and tested in actual practice over a 2-year period. The following strategies and procedures emerged. The person using these strategies and procedures needs to take into account several general basic principles apropos of any effective inservice or continuing education training enterprise:

1. You should always prepare your class by developing a prior set toward what they will be doing. This is accomplished by enough prior announcements so as to make clear when and where training will take place, who will participate, how much time will be spent, what is to be expected of them and of the instructor(s), what they can hope to get out of it (job or career enhancement?), and the like. Some of this should be done in advance of the class, some at the beginning of the first session.

If you are serious about training them you must make your training efforts serious. Your class will take it (usually) only as seriously as you do. Your nonverbal messages in that regard are probably much more important than your verbal statements, announcements, or memoranda. If the instructor is poorly prepared or not prepared at all, if the class is held in an inconvenient, unpleasant place subject to interruptions, disturbances, or constant annoyances, if classes are dropped (even for good reasons) or start late consistently, if materials and equipment (such as an adequate blackboard) are lacking, then whatever else you say, your class will not take your training effort seriously.

2. At the same time, you must see to it that the training you conduct is at the least pleasant, at best it can and should be intriguing, interesting, even fun. There is no reason for such an enterprise to be grim, dull, and boring. Use references, visual aids; have an occasional interesting visiting lecturer or interview; use role playing, demonstrations, experience sharing; offer refreshments or snacks; relax, be informal, use humor, and enjoy what can be for all a good experience.

3. Training should never be overly casual or too abrupt. No session should be less than 1½ hours with perhaps a short 10 or 15 minute break. Continuity is also important. Better a 2-hour session (or 1½ hours) every week than 3–4 hours every second or third week or once a month. This manual is geared to a 10–12 week series which will best facilitate the development of group cohesiveness (the feeling of trust in and belonging to). You will have gained an enormous advantage if you use the training not only to impart information, but also to develop a sense of confidence and trust on the part of the participants. This rapport will pay off not only in the short but in the long run. Therefore, do not use the class as a means of reading out or getting at your staff.

4. Be explicit, clear, and to the point in your discussions. Sometimes a side issue is important to pursue, but you should keep the class on track or bring them back when they digress so that you are not continually rambling off into endless confusion. You will want to draw out discussion from your class, but do not fail to make clear what it is you want and what the ultimate goals are, so that your staff does not have to assume or guess. Never let the class fall into petty bickering about a detail. If an issue is sticky, raise the issue in as concrete a way as possible and ask your class to brainstorm some creative solutions.

5. Continuing education is to be seen as just that. Everyone on the long-term care facility staff needs and deserves such an opportunity, even the night shift, office, and kitchen staff, etc. And they especially need this training series presented often enough so as to include all members of the staff.

6. Finally, some attention should be paid to evaluating your training programs. The trainer needs to know how effective the training is, where it is on target, where it needs improvement or revision. At the minimum you should ask for some evaluation during or at the end of the training series. In this regard, three questions which are useful to ask are (1) "What do you (or have you) found most useful or helpful about this class?" (2) "What has interested you the most?" (3) "What would you prefer to see changed (added, omitted, or given more time)?" In this instance, some followup of improvements in practice and behavior on the part of staff, or some survey (for which you might ask for assistance) of impact on the ultimate consumer, the resident, should prove revealing and useful.

Design

Each session in this training series was composed of two parts. The first part was designed to be a morning seminar (presentation and discussion) revolving around a central theme for the day, taking approximately 2–3 hours. The second part (originally given after lunch) constituted a clinical laboratory, that is, a session of 1½ to 2 hours or more of demonstrations, interviews, tape recordings, or films, designed to illustrate or demonstrate the morning theme.

To a large extent, these clinical laboratories can be incorporated into the seminar-type session. If the weekly sessions are to be limited to a 2-hour session, however, it would be wise to consider extending the length of the series (say over a 14 to 16 week period) so as to allow ample time to adequately explore all the issues raised in this manual.

COURSE CONTENT

Week 1

WITH WHOM ARE WE DEALING? IT ALL STARTS WITH ATTITUDE

How do you see the residents or patients you care for?

- Your personal view of the old, the incapacitated

- The difference between disabled persons or persons with a disability
- What are the capacities, potential, and future of the residents in your facility? (Write these on the blackboard as they are verbalized by class.)

STAFF COVERAGE

Who on the staff needs training?

- How does one select staff: "x-y" theory (the view some hold that staff are not worth training, hired hand, others: that staff can be trained and can do more.)
- Capacities and potentials of staff (write these on board as verbalized); discuss.

TRAINING YOUR STAFF

- *Why:* they are your policy implementers, they make it happen
- *How:* making learning and education important and enjoyable
- *What does your staff need to know?*

    Your answer and their answer (ask staff what they need to know)

    Verbal and nonverbal msesages (what you say vs. how you behave)

    Training methods and procedures (spell out the procedures)
- *Talking mental health jargon to your staff.*
- *Is jargon necessary to be understood? How can we make ourselves understood better by reducing jargon?*

IMPORTANT POINTS TO TEACH

- Learning can be fun and enjoyable; in-service should not be a drag
- Negative and positive attitudes towards aged residents generally held by staff persons and by older persons themselves. How this affects care.
- That old people are constantly underestimated; do have capacities, potentials, and futures. Discuss different goals for different persons.

Week 2

OBJECTIVES

- To become aware of some of the many possible events which may precede the admission of an elderly resident
- To understand the impact of the many losses that occur in the process of aging, i.e., physical losses, social losses, economic losses, loss of significant others, loss of role
- To show the importance of self-esteem in the total well-being of the aged person
- To encourage thinking along the lines of compensating for losses as the basic dimension of psychosocial (mental health) care.
- To discourage the view of the aging process as an incurable, irreversible disease.

RESIDENT'S CAREER PRIOR TO ADMISSION

Those Events in the Residents' Lives Which Led Up to Admission

- Many changes; most represent losses: Most losses are gradual, usually cumulative, and much variation (not at the same rate or extent between individual persons)
- Physical changes (losses): energy, sight, hearing, taste, smell, touch, cardiovascular, and cosmetic. Thus the body is not the same at 80 as it was at 35 years. Give examples of various kinds of losses
- Social changes: loss of family, friendship network is often disrupted: through mobility, through death, sometimes through divorce
- Economic changes: vocational and income loss; retirement, loss of home—many become poor when they retire; also loss of friendship network upon retirement; usually cannot compete in open-job market
- Cultural changes: loss of significant, meaningful, or desirable roles (the sick role); ageism, elderly are regularly devalued, often assumed not to be as competent or useful as younger cohorts.

Psychological consequences of such losses

Relation of self-esteem, aging, and competence

- The rise and fall of self-esteem: Self-esteem grows out of positive feedback from others; built on feeling of having impact on environment, of being an effective, competent person
- Function model rather than chronic disease model. We sometimes spend so much time on pathology and deficits of aging we give old age a bad name.

The notion of compensating for losses

- Example of things we attach to the body: eyeglasses, prosthetic legs, heart pacers are compensation devices
- Do not penalize the old for their losses, do not make it harder for elderly to function
- Going beyond barrier-free environments

IMPORTANT POINTS TO TEACH

- Losses over the years need to be compensated for so older persons can continue to function in spite of loss
- Self-esteem depends on a sense of competence, worthwhileness; this need for self-esteem is critical to well-being and good health of elderly.

Week 3

OBJECTIVES

- To list possible crises that precipitate admission
- To distinguish between a gradually developed vs. a crisis decision
- To consider decision-making about admissions
- To list important information needed on admission
- To define which types of admissions might be premature or unnecessary, and
- To ascertain what alternatives might be available.

CLINICAL LABORATORY

Role play

- A guilt-ridden, angry family, seeking information about admission (without the potential resident)
- A family accompanying the potential resident to admissions office

Role play from the experience of participants. Explain that they are to play the roles from their memory of such persons' behavior. Role play for a while, call a halt, and allow other participants to role play until practically all have had the chance. One person should role play the administrator, the director of nurses, or admitting clerk. Try combinations of these.

Have students draw themselves in old age in crisis situation which necessitates being sent to a nursing home. Discuss varieties of crises in elderly and prevention aspects.

FACTORS PRECIPITATING ADMISSION

A gradually developed or a crisis decision?

- How was your facility selected?
- Appropriate selection; lifestyle factors (Will lifestyle of resident be facilitated or frustrated?)

The family as a source of information

- What kind of history is important? Should you be concerned about health history? What about family relationships, family process?
- Direct and indirect means of
  - getting information
  - giving information
  - looking for tell-tale signs of strain between family members; tendency to con the potential resident; what information is obviously omitted?

Is this admission right?

- Premature or unnecessary admission?
- Can the family really care for relative? Will this do more harm than good (is this a dumping phenomenon)?
- Are there real alternatives?
  Who makes the decision? Do you tell them or explain the alternatives and their relative merits? Do you counsel or refer? Should you help the family and how?

IMPORTANT POINTS TO TEACH

- Gradual vs. crisis decision
- Older person needs time to adjust to change
- Increase the supports by staff for all newly admitted persons
- Share information with one another.

Week 4

OBJECTIVES

- To explore and describe the attitudes and moods of residents upon admission
- To sensitize the effects of first impressions
- To develop new and better ways to orient the new resident and soften the transfer trauma.

CLINICAL LABORATORY

Use and discuss the tape "You Are Not Alone" (A).

RESIDENT AT TIME OF ADMISSION

How does the resident view the move into a facility?

- What has he been told or not told about the move?
- What about the resident who has been conned or misled; what about the resultant confusion?

What are resident's biases, expectations, attitudes?

- Toward the family. Good or poor family history? Is resident angry at members of family (does resident exploit this through guilt)?
- Toward the facility? Write on blackboard the biases verbalized by staff; how to deal with negative ones.

What about first impressions of the resident?

- Give examples from own experience how first impressions work, good and bad; first impressions of seeing something unpleasant through an open door; how can this affect the new person?

ORIENTING THE NEW RESIDENT

- Recall the losses of the older person; in addition to problems with vision, hearing, etc., now he must adjust to a new, strange place. Need to see the whole facility (upright not horizontal).

Purpose of introduction, use of first names?

- People are important (roommates?) Who does what? Whom to go to? What the new resident can expect.

Thorough familiarization (need to repeat)

- Do not assume a one-trial introduction or tour is sufficient.
  Daytime tour, night-time tour (use of a picture, a map, or a buddy). Residents as hosts or hostesses.

Providing sufficient support, reassurance

- What about a coffee, tea, or milk snack time at admission?
  Use of prior contact by someone in facility (a resident or staff person). Familiar objects (furniture? hobby items? pets?).

IMPORTANT POINTS TO TEACH

- Importance of honesty with the aged about the move. How to deal with resident. Let resident know what reality is
- Importance of orientation and repetition
- Importance of support and reassurance for new residents, who are fearful, frightened, under stress.

Week 5

OBJECTIVES

- To see the value of getting to know the family and their background as much as possible
- To develop a sensitivity to the dynamics of the family situation in first contacts with the facility
- To learn how to develop realistic expectations on the part of the family
- To help the family become a resource to the staff.

CLINICAL LABORATORY

Show film "The Eye of the Beholder" (B) which illustrates differing perceptions of the same events (about 25 minutes).

or

"Home for Life" (C), a semidocumentary on the entrance of two older people into the Drexel Home in Chicago (2 reels, about 75 minutes). Excellent for showing interaction with relatives.

or

"To Live with Dignity" (D), describes treatment program for very confused elderly persons (about 28 minutes).

THE FAMILY AND ADMISSION ADJUSTMENT

Taking a good look at the family

Family distress; in crisis

- Dealing with stress, guilt, hostility
- Write on blackboard all the feelings staff see in such family members; discuss the element of stress factors
- What they ask and do not ask
- Write on board kinds of questions asked by family; which can facility really meet? (example: provide 24-hour supervision?)

Intrafamily relationships

- Good or bad—when does staff become targets of bad family relationships; how to deal with these incidents.

Helping the family take a good look at the facility

First impressions of facility

- Whom should family meet? Many more

than administrators and director of nurses; should family get to know staff and their functions? Night staff.

- Under what circumstances; how informal, how personal; when would small family groups and staff involvement make sense?

Developing realistic expectations

- What facility can and cannot do; facility would not do if it could (surveillance 24 hours); how much discussion with family to explore and make clear. What is the payoff?
- What is family's role? Do they need "piece of action"? In what ways family members can be helpers (write on board); family as a resource; how best to deal with chronic complainers.
- How well do relatives understand programs and goals? It is possible for staff to counsel the "fear merchants", "bomb droppers."

IMPORTANT POINTS TO TEACH

- Families in stress need help
- They need to understand clearly what facility can and cannot do
- Need roles as helpers, as resources.

Week 6

OBJECTIVES

- To increase understanding of person or environment interaction [3,4]
- To make aware of the internal and external barriers
- To sensitize to the meaning of certain kinds of behavior [5]
- To help develop understanding and skills in preparing nursing care plans.

CLINICAL LABORATORY

- Interview one or two residents in such a way that group can develop an on-the-spot care plan and discuss.

RESIDENT'S "CAREER" FOLLOWING ADMISSION

Facility is a life-space and processing system

- Resident and facility: how each affects the other. Individual person responds to (and behaves) his "internal" environment as well as to external factors; in turn affects everything around him.

Your facility: a community within a community

- The inside barriers; important to find out which events affect resident and how they do so.
- The outside barriers; lack or availability of transportation, getting around; attitudes of communities toward the old; events that occur outside the facility, yet affect resident.

Withdrawal and isolation as signals

- Attention-getting strategies; angry behavior; much crying behavior, complaining about physical aches (socially acceptable?)
- Dependence versus independence; these are "relative" states; better term for independent might be self-sufficient.

What is your plan, long- and short-term?

Nursing care plans

- Are they relevant and appropriate to needs of person? Ask person.
- Who prepares it? Who contributes to it? All who affect the individual person (all staff, family?) should contribute something; should it include only medical information?

Keeping track of the action

- What should be charted, and how; should be very explicit, descriptive rather than interpretive
- Who should chart?
- How does all relevant information get incorporated into record?

"Confusion"; fact or artifact

- Competence and function of the resident; word "confused" is too vague and over-used; confused with respect to what?
- Self-perceptions, staff-perceptions, misconceptions; how staff can validate their perceptions of residents.

IMPORTANT POINTS TO TEACH

- Atmosphere of the facility is affected by behavior of residents and vice versa
- Some behaviors are attention-getting strategies and signal real needs of person
- Care plans are guides and should lean heavily on needs and desires of resident [6]
- Charting is important as ongoing guide

to care and as a background of the person; requires great care.

Week 7

OBJECTIVES

- To increase understanding of the relationship between self-esteem and making an impact on one's environment
- To explore ways in which staff can help residents create a broader range of meaningful activities
- To sensitize staff to the fine line between truly helping the old and infantilizing the old.
- To develop creative solutions to the problems of loneliness and needs for affection by the elderly.[6]

CLINICAL LABORATORY

- Demonstration of various kinds of meaningful activities.
- Consider using an activities consultant who will give specific illustrations and examples. Use videotape "Geriatric Calisthenics" (E).
- Interesting discussion of how sexual matters are handled in facilities if videotape is not available.

NEED FOR INDIVIDUALIZATION

Personalizing one's space

Making an impact on one's environment

- Personal mementos, furniture, and clothing. The issue is personal identification; familiar items throughout the facility; who buys or selects colors, clothing, and furnishings?
- Schedules, "pacing": for whose benefit? These should be geared to needs and capabilities of the resident.

Fostering a sense of usefulness

- Meaningful activity—with purpose; need to avoid busywork, demeaning enterprises.
- Should only staff handle money? Should women carry purses? Why?
- Issue of what the individual person still controls.

Infantilizing the old

- Need for safety, protection, but . . . ! if staff does too much, what does this do to resident?
- Is there such a thing as too much TLC? Not too much TLC; taking away self-sustaining effort can make the facility too safe at too great a price. What's the price?

Making it all worthwhile

The battle against loneliness

- Repairing the friendship network; how does staff fit in; do staff see themselves in a larger role?
- Need for privacy (confidante).
- Oldsters weather problems better if they have a confidante; how privacy options fit in; how can this be arranged?

Who is available

- Others beside staff who help reconstitute friendship network; volunteers, family, children.

Companionship, affection, intimacy (sex)

- Are they needed? Review losses, including social; affectional needs.
- Are they possible? Enormous need (talking, touching). Easiest of all losses to compensate; every staff person has favorites—this is the starting point; opportunities?

IMPORTANT POINTS TO TEACH

- Need for personal impact on one's environment
- Essential to have a reason to get up for in the morning
- Too much help diminishes self-sufficiency (infantilizes)
- Sexual behavior (closeness) is not inappropriate in later years
- Appropriate opportunities must be available.

Week 8

OBJECTIVES

- To increase awareness of the importance of environmental cues for older persons
- To sensitize to the value of environmental stimulation
- To develop creative solutions toward an enriched vs. sterile environment
- To point out the role of staff in becoming part of an enriched environment
- To demonstrate the negative effects of a filtered environment

CLINICAL LABORATORY

Do sensory deprivation exercises:

- Have class write name and sentence with left (or nondominant) hand
- Plug ears with cotton, blindfold securely, then have each participant wheeled around in a wheelchair (through facility) for 3 or 4 minutes. Exchange with partner.
- Blind man's walk. Blindfolded, have each led around (also around obstacles) by partner. Exchange with partner.
- Discuss: how each felt about experience (what was good, bad), how partners led the other, how to improve such procedures, implications for policies of the facility.

THE COMPENSATING ENVIRONMENT

EFFECTS OF ENVIRONMENTAL CUES

What do cues do?

- They orient as to time, place (reality training); requires more than 1 or 2 hours per week—a constant; not a "game."
- Help maintain effective functioning. Principal goal is to help to function in spite of losses.

How cues do their work

- Work through sense modalities (sight and hearing); all sense modalities should be used as much as possible
- Clocks, calendars, designs, photographs, ID cards. Clocks and calendars large enough to be seen from a distance; should help people get around and use the environment appropriately; reduce ambiguity and confusion.

MAKING THE ENVIRONMENT WORK AS A PROSTHETIC AID

Not merely interior decorating

- To provide maximum stimulation; because of hearing, and other physical losses, older persons often need more intense experiences.
- Variety, adventure, change, new learning. Need to remember that the environment must provide all this. Since resident is usually embedded in environment 24 hours a day, environment should not diminish experiences (staring at wall from a clean bed is no career).

Enriching the fabric of existence

- Color, light, texture, as aids

  Are plants, pets, pictures, hobbies just frills? What effects do these have? Can you have too much?
- Do the old need leisure time activities?
  - reading
  - games
  - exercise programs (rhythm)
  - excursions
- The quality of these activities is critical; important to present the maximum number of options, not geared to the lowest common denominator

People as environmental stimulators

- Role of staff: walks, humor, reminiscing, gossip
- Visitors: children, volunteers, family
- The cocktail hour, the snack time
- How to get in touch with the out-of-touch

IMPORTANT POINTS TO TEACH

- The important effects of environmental cues and stimulation
- The many different positive things to be done which cost little or nothing in money
- Cues need to be appropriate, relevant, and useable for the population served
- People of many ages are part of environmental enrichment.

Week 9

OBJECTIVES

- To develop understanding that the source of authority lies in the concurrence and cooperation of those led
- To develop more effective communication channels, techniques, and processes
- To sensitize to the more subtle (and sometimes more powerful) reasons why people work [6]
- To increase awareness of those factors which affect morals, increase dependability, enhance loyalty, thus reduce turnover rate.

CLINICAL LABORATORY

- Do role playing with four or five members of staff, each playing the role of another staff person and taking turns playing role of administrator and director of nursing.
- Short 8–12 minute sessions should explore staff needs, communication problems. Discuss.

- In addition, write on board those things which staff verbalizes as needs, incentives, motives for working, communication problems.

DEVELOPING AN EFFECTIVE STAFF

Getting things done through people

- Process approach: source of leadership and authority; goals, policies, procedures all related to people
- What the role of staff is. Staff are those who make it all happen, for good or ill; role of staff is crucial

Effective sending and receiving of messages

- Staff-administrator; staff-staff; staff-residents
- Disruptors of good communications; "mixed messages," nonverbal message says one thing, behavior says the opposite; not listening (distracted by other things); need to acknowledge messages.

Staff Needs

What do people work for

- Motivation and incentive; nobody develops loyalty to a paycheck; what are other motivations, incentives?
- The job as a career; need for getting ahead. Do staff people see themselves other than as hired hands—can this work be a career?

Reducing staff turnover

- How do you develop dependability; seeing the larger role, the tie to resident care itself; need to be needed
- What builds loyalty?
  How much job satisfaction and program satisfaction do staff members get?

IMPORTANT POINTS TO TEACH

- Staff person makes facility run, is the source of its being a good, bad, or indifferent facility
- Effective communication is absolutely essential
- Nonverbal communication is as important as verbal communication
- Must understand incentives for which people work.

Week 10

OBJECTIVES

- To explore ways in which job satisfaction can be enhanced and loyalty developed
- To get staff to develop mechanisms and methods for recognition of service, status, and reward
- To encourage greater staff input and participation in problem solving
- To sensitize to the resident's need for sharing at time of impending death
- To increase understanding of the potentially traumatic effects of death transfers

CLINICAL LABORATORY

- Second part of this session (see outline following) might be reserved for one additional session, and in its place a second testing (evaluation) be administered. Refer to the evaluation procedures in the introduction and the introductory session.
- Time needs to be allowed to finish discussion of heavy material of morning, e.g., suicides in facility, unusual deaths, grief work. Also can discuss problems such as who pronounces patients dead, and when, how the terminal patient is handled—where is he or she placed in facility, isolation and special religious procedures, for example. One facility had ward for terminal patients with seven beds. What are the pros and cons of such an arrangement?
  (If this is the last class, help students with termination process.)

BUILDING STAFF MORALE

Appropriate Rewards for Staff

Is pay the only reward; is it sufficient?

- Need for interesting work; are staff focused on a job or a program?
- Need for status, recognition, satisfaction
- In what ways are special efforts rewarded? Can status symbols be built in? ID decals, pins, certificates, staff of the month, business cards, etc.

Should staff help you solve your problems?

- How can they help; what resources do they offer? How much input; problem solving only for their own job?
- Representation (staff council?) How much information (financial, for example)?

DEALING WITH CRISIS SITUATIONS

Death and Dying: what are the issues?

- How does it affect your staff; not affected if do not talk about it?
- Who deals with it; what about staff hangups? Talk it over? How to deal with it: can you always ask the dying person, "Would you like to talk?" What about families?

Suicide and grief work

If grief is ignored, will it go away? Why staff should not or should get involved?

Transfer trauma (loss of roommate)

- Inhouse transfer; should the truth be told? What is reality?
- Transfer away from facility
- Is resident prepared? Does it make a difference?

Crises away from facility

Things that happen outside that affect resident: death, accidents, marriages, politics

IMPORTANT POINTS TO TEACH

- There are numerous ways to provide rewards, status, recognition
- It's important to know what staff say is rewarding to them
- Crises do affect people; dying is an experience that most want to share
- Staff needs to be sensitive to the potential impact on residents of a variety of changes and crises.

Some Observations

Our training sessions were rotated among the facilities. On each occasion the host facility provided an extensive tour of the facility for the group which proved to be in itself an illuminating and instructive experience. Staff of these facilities, as had previous ones, also made special efforts to make the Wednesday sessions pleasant and convenient by providing refreshments during the sessions and serving a hot lunch.

Again, we had the initial impression of dealing with the cream of the crop because of the obvious alertness, good intentions, and astuteness of the group. Yet here too our discussions elicited some degree of paternalism (sometimes toward staff), tendency to infantilize the elderly, and tendency to mistake cleanliness, orderliness, proper diets, and medical attention for a worthwhile and meaningful way of life.

It also became plain that travel logistics required a modification of the teaching schedule. Consequently, we compressed the training into a 10-week period which proved to be close to the minimum length of time necessary, not only to cover the material and issues but also to develop the group cohesiveness, which proved to be so large a factor in achieving some of the stated goals.

We had by this time also been convinced that our original notion of maintaining the same instructional input throughout the series (rather than a series of lecturers) was most effective in maintaining the thematic approach (compensation for loss) and facilitating group cohesiveness.

It was also brought home to us how important it is not to take too much for granted when it comes to training or continuing education programs. In a discussion at a followup session in one facility which impressed us as having a particularly effective and knowledgeable staff, we heard feedback from staff regarding this training program (which provided for a mix of staff in the followup group): "You get the perspective of other shifts, who see the patients differently," said one. Another commented: "You learn all sorts of things about the patient which never gets put on the Kardex."

Dispelling Myths and Stereotypes About Aging

This training also provided a wonderful opportunity to discuss and dispel many myths and stereotypes about aging. One extremely effective method we used regularly to help students get a subjective sense of some of the losses in old age was the method of blindfolding, stuffing cotton in ears, and pushing the person around in a wheelchair; blindfolding and being led by another (blind man's walk); attempting to write with the nondominant hand, etc.

Responses to these experiences, which we always discussed at some length and used as the basis for effecting procedural changes, were frequently dramatic. Reactions of students and staff alike ranged from amazement and open-eyed surprise to near-nausea (following the unfamiliar experience). Several groups of staff, often because of experiencing and discussing these quasi-sensory deprivations, decided on a new policy of never pulling a resident backwards in a wheelchair, always pushing a wheelchair slowly, always gently alerting the resident in a wheelchair (especially if blind) before pushing it, and alerting the blind resident being pushed in a wheelchair as to what to expect next.

Sexuality and Aging

Discussions of sexuality and the elderly resident elicited many mythologies, prohibitions, antipathies as well as many empathic and supportive attitudes. In several facilities, we found aides and nurses alike who did not believe old men or women were really interested in sex or intercourse. A few verbalized the sentiment that it is wrong in old age, and one aide rather emotionally expressed the view that she believed it her God-given duty to stop any such activity whenever she saw it. One registered nurse who had initially expressed distaste about the whole idea said, "I'm not running that kind of home." Rather amazingly she had completely reversed herself by the end of our training. We believe that this change in attitude was largely a result of our frank discussions on the matter.

Many times the staff (sometimes to the surprise of the administrator and director of nurses) would rise to the occasion. For example, when the instructor suggested arranging for a private or intimacy room, several times staff immediately began to discuss which room(s) could in fact be so designated. One director of nurses was surprised to learn that an elderly resident's wife came in daily and took a nap with him, something which the staff had known for a long time.

The greatest difference our training program appeared to make from the outset was that it enabled these key persons to focus on dimensions of care other than public health issues as they had not done before. This focus in turn led them to begin to sensitize their staff to environmental factors which influence behavior, ways in which compensations for loss can be built in, and the like. There appeared to have been some difficulty encountered by several facilities in getting this type of continuing education program started, but all eventually managed to do so consistently and effectively.

Experiences With San Jose Group

By the time we began plans to approach the San Jose area, we became aware of some rather extensive publicity given to this project via newspaper items, several appearances on TV local community interest shows, a number of radio interviews, and by word of mouth; also by students in our classes, talks to various groups, contacts with a variety of professional associations, and governmental and educational groups.

We, therefore, had many requests either to (a) bring the training series to areas of the State other than those scheduled, or (b) offer condensed versions (2 or 3 days) of the training to interested groups, or (c) to expand the number of participants in our regular training so as to include many more persons than we had envisioned. In a modified and attenuated fashion we attempted to use all three options, although we were aware that we had not been able to respond except in a limited and selective way to the enormous need and demand. We had also established a good working liaison with the Center for Training in Community Psychiatry, especially in the north of the State.

The mental health consultants, most from county public health, who participated in this group session provided most of the followup observations and support.

The San Jose group, probably more than any other, proved to be something in the way of a study in contrasts. For one thing, most of the group members not only were acquainted with each other but many of them had worked together in the local facilities in a variety of combinations. Secondly, we observed the greatest top level turnover rate during our 10-week teaching tenure in that area. Three administrators were fired or quit, four registered nurses or director of nursing lost their positions or quit, and something approaching the wholesale firing of one staff was in evidence, although only three facilities accounted for most of this turnover. Also some of the best and some of the poorest continuing education inservice programs observed came out of this group; these poor quality programs were directly traceable to the attitudes and policies of the key people in the facility.

Most of the group members seemed interested and involved in our training course and appeared to be receptive and responsive in a positive way. The followup training in one facility appeared to be consistently lackadaisical, at best; all the others exhibited a uniformly serious attempt to institute a worthwhile continuing education program, ranging from good to excellent. In spite of the ups and downs experienced in and by the group, morale for the most part seemed to remain high.

The conduct of the final group required careful logistical planning and support. We learned that the administrator and director of nursing had maintained their personal enthusiasm for attending but that their authority to do so had been withdrawn by the owners of the facility. The owners maintained that such a program was not vital to the facility and was too costly in terms of the time demand on the administrator and director of nurses. Indeed, one owner-administrator attended the introductory session only, leaving it up to his director of nurses (as acting administrator) and one of the young office workers in the facility (as acting director of nurses) to represent that facility.

Our experience here again provided strong indication that such absentee owner-administrators are usually the persons most likely to need a course on the psychosocial dimensions of care. There is more than a little evidence that the conscientious on-the-scene administrator often does not receive the support required unless the absentee owner-administrator (or board of directors) is sensitive to and cognizant of the administrator's humanistic goals.

As already indicated, there were times when the administrator on the scene did not get the support a truly creative, innovative, humane effort really deserved, but this absence of support was in part compensated for by the administrator's unusual devotion to the job and to the residents.

This training not only appeared to stimulate new ways of looking at and planning of policy for the residents of facilities but also stimulated new ways of perceiving staff, and new creative approaches to staff by the administrator, the director of nurses, and the mental health consultants.

Recognition of Staff

A number of specific procedures were instituted to enhance opportunities for appropriate recognition of special service, initiative, or faithfulness on the part of staff.

As one example, we might cite the graduation ceremonies arranged by one facility and to some extent replicated by several others. These ceremonies were held at a time set aside for invited guests to attend (which included a city councilman who presented certificates). This event included a great deal of attendant publicity which placed a great deal of importance on continuing education as an inservice function for staff and also did much to enhance the status of the participating staff. One person on the staff indicated the importance of this training and the graduation to the administrator and director of nurses by stating, "This is the first time in my life I've taken part in any kind of graduation exercise."

The granting of college credit by a nearby community college was also arranged for those staff who participated in the followup training sessions. This recognition was perceived as a significant breakththrough and the setting of a precedent for future collaborative efforts between community colleges and nursing home continuing education programs.

The final training of this group also represented an interesting mix of participants and circumstances in that it brought together persons relatively new to the nursing home field with several who had a considerable amount of experience in the field—plus a scattering of those in between. These persons also represented facilities that ran the gamut of long-term care: retirement residence, intermediate care, skilled nursing home, "L" facility, convalescent care, proprietary and nonproprietary facility, and State hospital.

In the last training series, we were able to crystallize and underscore the commonalities and overlapping interests and concerns, especially with respect to environmental factors. To some extent we stimulated these key people to mobilize themselves toward collaborative activities which would enhance their effectiveness within the facilities themselves and within the community. Planning for more newspaper publicity and for a newsletter were a few of the activities planned by the participants of facility programs; for example, the director of nurses also generated plans to involve herself more fully in a community organization of directors of nursing which included general hospitals in the area.

Some Results of Training

It is fair to say that as expected, we never left the staff of the facilities exactly as we found them. In many facilities, the changes observed were substantial, had significant impact upon the life of the residents, and portended permanent change.

These changes ranged from increased decision-making opportunities for residents to greater environmental enrichment via stimulation and cues, through increased attention to staff needs and sensitivities, to increased use of volunteers, and to more time, attention, and effective procedures with families and community. Communication among all staff members was consistently noted as improved and increased by the training.

In addition to these immediate changes and those changes which were planned, a number of indirect benefits were realized. Some of the most gratifying were as follows:

All participants had the opportunity to become more familiar with some of the resources available to them, including those of the University of Southern California Gerontology Center. Its function and programs were discussed with every group and with staff. Such professional associations such as the International, National, and Western Gerontological Societies were brought to their attention, and a number of the participants subsequently applied for membership. Other students enrolled in classes or enrolled in other training programs.

Medical Students Allowed to Visit Homes

A group of first-year medical students ("Introduction to Clinical Medicine") from the University of Southern California Medical School pioneered a program of visitation to one training facility. These students had the opportunity (early in their training) to interview elderly residents and discuss the psychosocial dimensions of care at length with us and the key people participating in the program. Since that first group, which started more than a year ago, we have arranged a similar experience for three other groups of medical students.

More often than not we had found owners of many nursing homes reluctant at best to have students come into the facility for training, research, or survey purposes. Almost without exception, the facilities in which we have done training have completely reversed this attitude. They have shown themselves cooperative and hospitable in providing (upon request) free entrée and the appropriate kinds of opportunities for graduate and under-graduate students, from medicine, psychology, nursing, and social work.

Language and Vocabulary Difficulties

In several facilities a language problem surfaced, because some of the participating staff were more comfortable with Spanish or Portuguese than English. We had the protocols written in Spanish to assist them with the training. We found further, however, that not a few staff, because of minimal formal education, had considerable difficulty, not only with the meaning of certain words and concepts, but also had some difficulty actually understanding how to fill out the protocols as per instructions.

Staff Benefit From Continuing Education Training

The staff of a number of facilities, following training, have reached out into their various constituencies as never before. The most noteworthy of these was a program for selection, training, and followup of new nurses aides, which was organized by an administrator of a convalescent hospital in collaboration with the community college system there.

Increased efforts to provide recognition and status for staff were observed in several facilities such as awarding special pins and giving days off with pay. Other ways of emphasizing their larger role were by giving annual staff picnics, presenting award certificates, and having aides present case studies in staff meetings.

One facility began a policy of requiring proof of attendance at continuing education classes before paychecks could be obtained. Another now requires willingness to participate in continuing education programs as a condition of employment.

Help From Indirect Service Staff Encouraged

Students began to encourage nondirect service staff (such as secretaries or maintenance men) to interact with residents and other staff. A secretary, for example, was encouraged to bring a cup of tea to a fearful and harrassed resident. In another instance, a member of the kitchen staff, who had been with the facility more than 20 years and who was seen by residents as a friend and confidante, was a virtual storehouse of information about many residents, information which had never gotten into the formal patient charts. He, as a result of a long followup discussion on this, was encouraged to write this information into the Kardex. He obviously felt flattered by this and much more a member of the team.

Also, aides at one home began using the break to take residents to activities programs. They had never done so before, had suggested the innovation, and were encouraged in this by the administrator and the director of nurses.

Meaningful Activities Helpful to Elderly

In conjunction with this program, we also encouraged administrators to find meaningful work for residents. All too often when a person retires or can no longer maintain his or her own home, he or she feels put out to pasture and no longer able to do anything useful. This feeling, of course, leads to depression and a lessening of the will to live.

Staff of some facilities gave residents simple tasks such as mending a bedspread, or emptying their wastebasket, or looking after their roommate to provide a sense of being needed and being productive. These jobs, of course, should be geared to the abilities and willingness of each person.

Visual aids and verbal reinforcement are helpful in reinforcing the date and time. Lest any of us forget how much each one of us depends on these things in his own life, picture yourself on a 2-week vacation with no appointments to keep, no watch or calendar, and no secretary to remind you of things. At the end of that time, you probably would have lost track of a number of things and become somewhat "confused." It is no wonder then that many residents, who have not had to keep appointments or worry about time for months or years, can become "confused" about many things.

The project was funded for a second year with the important added consideration that we extend this training model into other areas statewide and that we include other components of the system, that is, the surveyor (inspector or field representative) group and use the community college systems. Obviously the State inspection process is a part of the long-term care system and the desirability of a consensus about means and ends on the part of inspector and administrator of long-term care facilities is hardly debatable.

We had also been impressed with the growing need (and pressure) to develop resource and training programs relevant to and appropriate for long-term care. The community college system would seem to be potentially the appropriate locus in various locales to serve both as a stimulus and as a source of training. As we organized the second year, consequently, we paid a great deal of attention to these two aspects.

Communications (via letters, telephone calls, and personal trips) described and interpreted our training to the reorganized State Department of Health, Licensing Division. It appeared that internal reorganization problems of that department preempted most of the time and attention they could give us, and at best, we were able to get only a limited amount of participation on the part of surveyors.

We learned, too, that our original sequence of presentation proved to be the most useful. We had become aware that issues relating to staff were raised by students early in our training session, even though these were not scheduled for discussion until the end of the series. So we decided to start the training of the third group with such issues rather than reserve them for a later discussion. We discovered that such an early discussion of sensitive and potentially disturbing material so early in the game, before a comfortableness with the group and willingness to share had time to develop, became disruptive even to the point of near disaster. Thus we reverted to dealing early with those issues involving residents or patients, about whom these key people obviously felt somewhat more distant, reserving discussion about staff for a later time.

One major task in training was to help participants identify and specify the salient issues and to find ways in which to translate or transmit the goals of these key people in useful form to their staffs. Here the strategy of helping to make the connections between what staff does and how the environment is designed and the effect, good or bad, upon the resident, had especially good results.

After much discussion of this issue, one nurses aide who felt overly harassed by so many feeders decided at least to improve the social graces. She dressed her charges nicely including jewelry, earrings, and makeup, announced that they were all going to lunch, helped them to an assigned area, and appointed one to be hostess. She reported later that not only were these residents now looking forward to mealtime as a social event but also there was a marked improvement in self-sufficiency with eating.

Equally important would be verbal reinforcement of time, date, and surroundings by everyone who comes in contact with the resident. These contacts mean staff, volunteers, students, visitors and most important, the family who must remind residents of time, dates, and important events. It is important that residents know who they are, where they are, and why they are in the facility, and they must accept these facts before they can become actively involved in the activities of a long-term care facility. Remembering the past is a wonderful thing but living in it leaves no room for enjoying the present.

We decided to keep a continuing log of observations of the behaviors, policies, and programs of students and staff, and to record such changes as appeared to flow from our training which would be expected to result in a positive impact upon residents.

Environmental Changes and Stimulation

Staff of one home began a program of environmental stimulation by painting the rooms with bright stimulating colors and using bright colored bedspreads geared to residents' tastes. New calendar clocks with large enough numbers that could be easily read at a distance by persons with poor eyesight were given the residents and pictures for wall decoration, directional signs in halls, names, and mailboxes on each resident's door were also added. One director of nurses proudly announced to her staff that she was arranging to have four large murals of the four seasons placed on the walls of the dining room. Also that she was going to have some full length mirrors installed at various places in the building for use by the residents. One home installed individual bulletin boards in each resident's room.

One facility gave each corridor a street name with an appropriate street sign, so that each resident would have an address, rather than just a room number. The administrator of another nursing home, which had a number of identically designed and identically painted buildings within its complex, decided to add critically needed environmental cues by painting each front door of the various buildings a different bright color, and in another home, a number of doors within the building were painted a bright solid color. Administrators of several facilities announced a policy of "dehospitalizing" the atmosphere by encouraging the use of street clothes or colorful slack suits by their aides.

In many of the homes activity clubs were started. These clubs included cooking clubs, garden clubs, exercise clubs, dancing classes, gin rummy clubs, crafts clubs, sewing clubs, beauty classes for women (how to give facials), and plant potting classes.

Administrators of two facilities began to explore the stimulating effects (upon residents) of different kinds of music played in public areas, and music was played during mealtimes in another home.

Attempts were made to enrich the environment through various means of stimulation; e.g., one home acquired a large aquarium, another explored the possibility of individual pets.

One home did acquire a pet dog, and when the dog trotted down the halls, many a hand of a wheelchair resident could be seen reaching out to stroke or touch the pet. Another had baby chickens for residents to watch and feed. Birds and aquaria were also in the process of being acquired. Residents in some of the homes were allowed for the first time to have plants in their rooms.

Another invited children in (after conferring with residents) for "trick or treat" on Halloween. One home organized "kiddie corners," that is attractive cabinets installed about the premises which contained toys for the children who were brought along on visits.

More Consideration Given Personal Feelings and Desires of Residents

One director of nurses changed the policy of making inhouse transfers without discussion with and the advice and consent of the residents themselves. This procedure was a clear break with previous procedures. This new policy included procedures to reassure the transferred resident.

All the facilities determined to change their (usually unannounced) policy of playing down discussions of dying with people in terminal stages. This change in attitude was directly related to our own Wednesday sessions on the subject and the need for the students to discuss the issue with their staffs.

Several administrators announced their intention to institute a new policy of encouraging more dialog between staff and residents relative to resident's options and choices about many matters of daily living—food and snack choices, time of bath or shower-taking (one facility changed its policy of insisting on baths only in the mornings), choices of activity program, etc. This policy was associated with the stated intent of administrators to begin to encourage their staff to look for the potential of older residents.

In several homes we observed more serious attention being given to the development of nursing care plans, including the psychosocial components, and a review and revision of older plans.

Two facilities began planning the organization of a "resident's council" to provide greater input into the administrator's and director's of nurses decisions regarding the operation of the facility.

Several introduced new policies regarding orientation procedures for newly admitted persons (tour of the facility, more introductions, and serving a snack).

Several tried role playing with staff for the first time which not only proved a useful teaching device but seemed to spark interest and leave a good taste in everyone's mouth as well.

Another home instituted a weekly "Town Hall Meeting" for all.

Another developed a trial program of sending a staff person to the quarters of a potential resident (one who had applied for admission) to develop a prior friendly contact to ease the transition trauma. This procedure was reported to the group as being so successful and useful that others were encouraged to follow suit.

Several policy modifications were planned to allow greater activity options and encourage greater participation in socializing on the part of the residents.

All began sensitizing staff to the need for greater care (that is, more alerting, more explaining, and more consulting) in the placement, displacement, and transferring of residents, especially those in wheelchairs and the severely disabled who required the assistance of staff in such movements.

After lengthy discussion with her staff class, one director of nurses announced that the admission procedure requiring a bath of every newly admitted person, whether willing or not, necessary or not, would be revised to meet individual need and willingness with consistent reference to maintaining the person's sense of self-esteem.

The visiting hour policy was radically modified in several facilities, so as to permit open hours for visiting by persons of any age.

Another which had used the services of an activities director part time now employed her full time. Also a chaplain was retained for family and residents at one home.

Inservice training sessions at another facility, in response to the clearly expressed desire of a number of residents, were opened for participation by residents of the facility. This revised policy was the result of discussions with the staff.

Publicity Helped

The project was widely cited, referred to, or described in some dozen newspapers nationwide, TV appearances were made, and approximately a half-dozen interviews were given by the staff to community local service radio. Throughout these media references, the underlying theme was the upgrading of the mental health and quality of life for the elderly in nursing homes by attention to those factors which compensate for loss and sustain self-esteem. The ways to upgrade and improve the quality of life were emphasized and many times spelled out. What was most impressive about these inquiries, publicity, and reception of articles was the information gap uncovered in the field of psychosocial care and the depth of interest in it.

EVALUATION AND DISCUSSION

Three methods of assessing the progress and impact of this action research-demonstration project were used. The most formal method was that of administering a pretraining and posttraining set of protocols to both students (the key people) and their staffs. At the beginning we had planned to include the entire staff of each facility in the followup training. It became apparent early that including the entire staff was not practical because we could not find a way to release all staff at the same time for training. Nonetheless, we repeatedly expressed our concern that those elements of staff which are usually shortchanged or left out of training programs altogether (e.g., the night or evening shifts) not be neglected in this program.

At practically every facility, however, they were able to arrange the attendance of a selection of staff fairly representative of each of the various departments (housekeeping, nurses aides, food service, maintenance, and office staff) with the provision that this training series be repeated until all elements of staff were given a chance to participate. As already reported, members of the staff themselves put pressure on the administrator and director of nurses to include them either immediately in this training or in the course of time.

The formal pre- and postprotocols were designed to elicit several different kinds of information. One category of information had to do with attitudes toward the old under several conditions, and for this we used the well-known semantic differential technique. A set of bipolar descriptive scales was headed by various contexts related to the old (old man in institution and old woman in community). The respondent was instructed to check his own descriptive preference on a negative-to-positive continuum.

A second protocol administered consisted of a number of statements or assertions having to do with (a) basic substantive information (*S-1*) ("aging is an incurable, irreversible disease"), (b) perception of the climate (*I-C*) of the facility ("patients here are treated with dignity"), and (c) attitude (*M*) toward the job ("I'm given all the information I need to do my work"). Respondents were asked to check each statement in one of four possible categories: strongly agree, agree, disagree, strongly disagree. In this manner, we hoped to be able to tap possible changes in attitudes, both with regard to the older person and with regard to the job. We also hoped to detect changes perceived by the respondents in the institutional climate and to get some evidence regarding our success (or lack of it) in communicating basic information.

Toward the end of the series the participants were asked to answer briefly two questions about the course: "What has been most helpful so far?" and "What should be changed?" A few selected verbatim responses follow:

> Better insight in seeing the patients' fears, anxieties, adjusting problems when necessity of admission to our facilities comes about.

> The necessity of inservice to nursing attendants in helping them to understand the tremendous losses patient is having to overcome and the need to help during these crises.

> Understanding of the family of the patient and understanding of the patient's day

> Direction in teaching methods.
> Good material to present.
> Association with others with same interests.
> Getting to know the instructors personally.
> Helped me to set some goals. What should be changed? It should be ongoing, not just 10 weeks.

> Enjoying a fresh new approach to looking at geriatrics and dealing with the problems of residents.
> Opportunity to pass this information to the best of our ability to staff through inservice
> Personal interactions encouraged and exemplified by instructors.

> The exchange of ideas is good. The topics of discussions are good. Very good stress on psychological needs has been done. More emphasis on importance of directors' influence on aides and how to get it. Need for specific class for directors of nurses alone.

We were aware of the possibility that attitudes as measured might appear to change but that practice might not follow suit. We were concerned with attitude change primarily as a precursor to policy or programmatic change (for the better). Obviously, as a practical matter, the best index of effective change encompassing quality of life is the impact of change upon the ultimate consumer, namely the resident.

We found not surprisingly a high correlation between premeasures and postmeasures of attitude toward the old, as well as a high correlation between contexts on the semantic differential. Essentially this high correlation means that a measurable attitude change was minimal with respect to the various conditions or situations of the old and from the beginning to the end of training. In other words, either the time was too brief or the measure too gross to differentiate attitude change. Although we summed scores for each protocol and for all respondents, it is possible that very fine discriminations were washed out in the process. In any event, respondents produced a score slightly more on the positive than negative side across contexts, and this score was maintained throughout training. Another possible explanation for these results is that by and large the respondents had a set to respond in a fairly positive way regarding their views of the aged as part of the "social desirability" phenomenon (the tendency to respond with what one perceives as a socially desirable response).

When it came to assessing the three factors embedded in the agree-disagree schedule of statements, namely, substantive information (*SI*), morale (*M*), and institutional climate (*IC*), a greater degree of discrimination became evident between sets and on predifferences and postdifferences. These differences were derived by means of a *t* test or predifferences and postdifferences between means of scores. Overall, *M* (that is, attitude toward the job) appeared to change slightly in the positive direction for staff persons, but not close to nearly conventional levels of significance ($p <$ .10). For students, differences between scores remained close to the chance level. Pre- and post-*IC* were also assessed at the .10 level or greater, which suggests that institutional climate is a somewhat more amorphous entity and to be able to perceive noticeable change may require (a) more time or (b) more marked, even dramatic evidence.

The same considerations, of course, may well be true of impact of change on the residents as ultimate consumers. The greatest amount of pretest and posttest change occurred in the area of *SI* for both students (at the conventional .05 level of probability) and to a slightly lesser extent for staff. From this information, we concluded that our basic information about aging was reasonably effective, did get across to our students, and was retained by them. *SI* data on staff indicated somewhat slightly less effective presentations by our students but given the differences in amount of time spent on our own presentations as well as familiarity with the material in contrast to the more limited time available for presentations of our students to their staffs, these results seem consonant with the input.

We also noted the variability between the different scores on *SI* and *IC* for given respondents. To some extent, this difference may be a manifestation of some of the difficulties experienced in administering the protocols.

During the first and second training session we relied heavily upon the administrator and director of nurses to monitor the pretesting and posttesting. After seeing what the difficulties were, we took it upon ourselves to oversee the pretesting and posttesting personally. Even at that, some slippage undoubtedly did occur, even though minimal.

As to the second major means of evaluation of the project, a number of observed changes in policy, procedure, and programs have been reported.

Evaluative Questions

Three underlying evaluative questions were embedded in this three dimensional model at the outset and required answering. The first was: Did the content and format of the training model significantly alter the trainees' (administrators and directors of nursing first, then staff) attitudes, level of sophistication, and behavior deemed relevant to upgrading the psychosocial dimensions of care? As already noted, the formal attitude assessment procedure (the semantic differential) indicated a negligible result in terms of the paper and pencil test.

The usual difficulties in assessing attitude change apply here. Whether these negligible results are a function of inappropriate or nondiscriminating techniques, or whether there was not enough time allowed for such measurable change to occur, or whether attitudes were skewed at the onset and thus not susceptible to marked change, remains a moot point.

Attitudes are extremely difficult to change. We did observe that many of the participants' rhetoric did markedly change, that is, they verbalized different (sometimes dramatically so) views, attitudes, opinions about their elderly clients, about staff's roles and their own roles, and the goals, responsibilities, and functions of their facilities. We observed increased attention and sensitivity to psychosocial issues on the part of students and staff alike which (by their own repeated statements) were markedly different from the past. Apart from the apparent sincerity in most of these expressions, what seemed most convincing about the expressions was that we saw a great deal of this rhetoric translated into specific behavior and performance, not only in the classroom but also in daily practice. Although this behavior would not appear to be mere rhetoric, we might expect then that demonstrable changes in behavior and performance in many areas can lead in time to attitudinal change.

We do not mean to imply anything like a total reversal. Much in the way of attitude and behavior was not bad to begin with. Second, much of the deficit with respect to some of these psychosocial dimensions (like the factors which affect self-esteem) which we have observed result, it seems to us, not so much from perniciousness but from ingrained stereotypes, lack of appropriate and relevant information, and failure at times to make the connections between causes (certain policies and procedures) and their effects (impact on the resident or staff member). A good example of this inappropriate change is a common phenomenon: in their anxiety to provide good care and safety for their charges, many staff members tended to go beyond the limits of behavior appropriate to this concern and end up infantilizing the old.

Thus, the changes in behavior which we had looked for and are reporting on were, of course, learned behaviors (learned in our classes). But these learned behaviors might be expected to be first approximations, and the reinforcement of these behaviors will require much more than such a demonstration project could provide. We were convinced that although many positive changes were evidenced, what was needed was, at the minimum, something in the way of periodic "booster shots" of continuing education about these psychosocial issues.

The second question was: What were the nature and extent of changes that might occur in relevant activities and programs in the participating facilities? The question of nature has already been touched upon. The extent of these changes, as we have documented, was such that they impacted upon practically all parameters of the long-term care operation. The issues we raised and discussed with our students not only related to direct patient or resident care with respect to services and environmental input, but also related to effective use and development of staff, effective dealings with and accommodations to family members, friends, persons in the community, agencies, and volunteers.

Our training also included (at times not by specific design) issues relating to the larger aspects of the system: the care and feeding of referrers (such as physicians and staff from hospitals for the gravely ill), surveyors, and legislators.

The third question to be considered was: Was the project as conducted a viable model for a productive, collaborative, multiorganizational relationship (a private institution of higher learning, a Statewide public mental health organization, and the long-term care facilities themselves) in conducting mental health continuing education programs for the elderly? Our collaborative experience appears to have been for the most part real, effective, and reproducible. In a number of ways (teaching, organizing, surveying, contacts, consultant help, and logistic support) we can see interlocking efforts provided by all three sectors. In that sense, this collaborative model did work effectively.

Basically, the key to this enterprise appears to have been the licensing and monitoring function of the State. By the process of requiring more and better ongoing training for licensees within the State, it has generated a demand as well as an incentive for such activities on the part of practitioners. This incentive (the need for "approved" continuing education hours) was a major factor in attracting many practitioners to our training course. The challenge to the instructor, of course, is to make the training worthwhile once the student has come.

In a real way, then, this project has demonstrated the way in which the needs of the three sectors can be served by a collaboration which grows out of their differing functions. Sometimes these functions overlap or replicate each other and then collaboration must assume another form. For example, the State Department of Health as well as the Nursing Home Associations themselves were into the business of training. The institution of higher learning could then collaborate by offering a consultative function.

Thus we believe that our project not only has made a significant impact upon staff of the facilities actually and immediately involved, but also has begun to infect (in a positive way) the broader aspects of the long-term care systems. Nonetheless, we believe that the evidence indicates that the surface has only been scratched. Other components of the system need to be reached and cultivated: physicians and hospitals who serve and refer to nursing homes; legislators and members of the bureaucracy who write laws and regulations which affect the operations, policies, and programs of such facilities, and other marginal facilities; staffs, administrators, and directors of nurses who have not yet recognized the crucial need for concern with the psychosocial care of the aged. This demonstration of a viable collaborative model is even now in process of elaboration so as to provide an effective response to continuing needs of the long-term care system. What this project has further demonstrated as effective and reproducible in continuing education programs for mental health in nursing homes is:

- Effectiveness of teaching onsite
- Necessity of training of these key people
- Importance of followup training of staff
- Effectiveness of peer training
- Value of emphasis on the prosthetic environment in psychosocial (mental health) care
- Intensive, indepth training
- Advantages of developing group cohesiveness in such training
- Importance of experiential learning exercises.

In all, participants from 32 different facilities were involved in the primary agenda of this action research program. They represented virtually the whole gamut of long-term care facilities in California (excepting board and care), with special emphasis on "L" facilities in keeping with the Department of Health's special concern. Participating regularly in the weekly training seminars and clinical laboratories were 87 nurses from these facilities. The others involved were five persons from community college systems, two surveyors, six mental health consultants, and three administrators. Ancillary training programs associated with this program reached an additional 35 persons from nursing homes.

The participants in turn gave weekly followup training to approximately 515 selected persons. This number is approximate because there was some shifting of staff as a result of personnel changes in and out of these training programs. In doing posttraining followup with these facilities, we noted that about 75 percent of the trainees were in process of giving further continuing education training courses with additional staff (involving an additional 210 persons).

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LIST OF EQUIPMENT USED

Description	*Address of supplier*
Tape: You Are Not Alone (part of series, The Ways of Mankind).	University of California at Los Angeles 405 Hilgard Ave. Los Angeles, Calif. 90024 (Experimental Social Psychology)
Film: The Eye of the Beholder (about 25 minutes, illustrates differing perceptions of the same events).	Stuart Reynolds Productions, Inc. 9465 Wilshire Blvd. Beverly Hills, Calif. 90212 ($25.00 rental for 3 days)
Film: Home for Life (2 reels, about 75 minutes, semidocumentary, excellent for showing interaction with relatives).	Drexel Home 6140 Drexel Ave. Chicago, Ill. 60637
Film: To Live With Dignity (about 28 minutes, describes treatment program for confused elderly persons).	University of Michigan, TV Center 310 Maynard St. Ann Arbor, Mich. 48104

Appendix

TITLE OF PROJECT, CONTRACTOR, CONTRACT NUMBER, AND NAME AND ADDRESS OF PROJECT DIRECTOR(S)

ADELPHI UNIVERSITY

Title of Project:

Mental Health in Nursing Homes Training Project, June 27, 1972—June 26, 1974

Contractor:

Adelphi University
Garden City
Long Island, N.Y. 11530

Contract Number:

HSM 42-72-218

Project Director:

Mrs. Elaine Goldman, Training Program Director
Adelphi University
Garden City, N.Y. 11630
Telephone: 516-294-8700 X7400

Subcontract:

Evaluation

Contractor:

Hofstra University
Hempstead
Long Island, N.Y. 11550

Main Contract Number

HSM 42-72-218

Director of Evaluation Project

Pierre Woog, Ph.D., Director
Ph.D. Program in Educational Research and Assistant Professor
Department of Educational Psychology
Hofstra University
Hempstead, Long Island, N.Y. 11550
Telephone: 516-560-3663

MASSACHUSETTS MENTAL HEALTH, GERIATRIC UNIT, AND BOSTON UNIVERSITY SCHOOL OF SOCIAL WORK—DIVISION OF CONTINUING EDUCATION

Title of Project:

Nursing Home Education Project, June 27, 1972—September 25, 1973

Joint Contractors:

Massachusetts Mental Health Research Corporation
74 Fenton Road
Boston, Mass. 02115

Boston School of Social Work
Division of Continuing Education
Boston, Mass. 02115

Contract Number:

HSM 42-72-220

Program Director:

Dr. Bennet Gurian, Director
Geriatric Unit
Massachusetts Mental Health Center
Boston, Mass.
Telephone: 617-734-1300 X388

Project Director

Mrs. Anne O. Freed
Family Services
34½ Beacon St.
Boston, Mass.
Telephone: 617-LA 3-6400

NORTH TEXAS STATE UNIVERSITY

Title of Project:

Evaluation of Continuing Education in Mental Health for Personnel of Nursing Homes, September 13, 1972—January 15, 1975

Contractor:

North Texas State University
Denton, Tex. 76203

Contract Number:

HSM 42-72-158

Program Director:

Dr. Hiram J. Friedsam, Director
Center for Studies in Aging
North Texas State University
Denton, Tex. 76203

Project Coordinator:

Mr. Bruce London, A.C.S.W.
North Texas State University
Denton, Tex. 76203
Telephone: 817-788-2064

UNIVERSITY OF SOUTHERN CALIFORNIA

Title of Project:

Training Project on Mental Health Aspects in Nursing Homes, June 27, 1972—September 26, 1974

Contractor:

University of Southern California
University Park
Los Angeles, Calif. 90007

Contract Number:

HSM 42-72-221

Project Director:

Dr. Albert G. Feldman, Associate Director
Community Projects and Continuing Education
Ethel Percy Andrus Gerontology Center
University of Southern California

Program Director:

Arthur N. Schwartz, Ph.D.
Ethel Percy Andrus Gerontology Center
University of Southern California
University Park
Los Angeles, Calif. 90007
Telephone: 213-746-5163

IOWA LAKES COMMUNITY COLLEGE

Title of Project:

Mental Health Inservice Program for Employed Long-Term Care Personnel, June 1973 —

Contractor:

Iowa Lakes Community College
101½ N. 6th Street
Estherville, Iowa 51334

Contract Number:

HSM 42-73-185

Project Director:

Mr. Eugene Schorzmann, Assistant Superintendent

Project Coordinator:

Mrs. Julie Souhrada, R.N.
Iowa Lakes Community College
101½ N. 6th Street
Estherville, Iowa 51334
Telephone: 712-362-7231

IOWA LAKES COMMUNITY COLLEGE

Mental Health Inservice Program for Employed Long-Term Care Personnel, June 11, 1973—

Prepared by Eleanor C. Friedenberg, Project Officer *

During the first year of the Mental Health Demonstration Model Training Project experience, it became apparent that a key element had been overlooked—the role of community colleges in the continuing education of long-term care personnel, particularly for paraprofessional and support personnel. In addition, the original projects had been located in predominantly urban areas and there was a need to address the special needs and problems of training in rural areas. The staff of the Division of Manpower and Training Programs, NIMH, decided, therefore, to develop an additional Demonstration Model Training Project during the second year, incorporating a community college in a rural area into the demonstration system. Staff began a search for a college with a demonstrated capability in long-term care personnel training in order to minimize the lead time required to initiate the project.

The Community Health Service, HSMHA, had contracted with the Iowa Nursing Home Association to conduct training on a Statewide basis, utilizing the 15 community colleges in the State system as principle trainers. One college, in particular, was interested in demonstrating a coordinated physical health/mental health training program and expressed this interest to NIMH. This college met all the requirements of demonstrated capability: location in rural area; access to mental health facilities also serving the same geographic area; and already actively involved in the Statewide training supported by the Community Health Service, thus maximizing the potential for a comprehensive training activity that could continue following Federal project support.

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* Material is based on monthly reports, site visits by the Project Officer, correspondence with the contractor, and an interim report prepared by the Project Coordinator.

In Spring 1973, a 1-year contract was negotiated with Iowa Lakes Community College, Estherville, Iowa, to conduct an ongoing inseservice training program for employees of the 13 long-term care facilities located in the five county areas of rural northwest Iowa, to demonstrate the role of the community college as lead agency in linking long-term care facilities and mental health services through the mechanism of continuing education with particular reference to the applicability of this model to rural areas.

The purpose of the project was to upgrade the knowledge of personnel in the mental health aspects of care of the aged and upgrade their skills to provide improved physical health care. All levels of personnel were to be included, but particular attention was paid to the training needs of direct patient care personnel, especially nurses aides. Thirteen separate categories of personnel were identified for inclusion in training. Some of the topics were appropriate for all; other topics were appropriate for only some categories and were attended by only those employees who could benefit.

The objectives of the program were:

1. To gain a better understanding of long-term care resident behavior;
2. To become aware of and understand patterns of behavior in residents throughout the aging process;
3. To improve the quality of nursing care;
4. To develop expertise in local teachers who will be able to carry on inservice education programs beyond the project period;
5. To provide personnel with an opportunity to upgrade their training at a low cost and with application to their work situation by conducting the training in the facility where employed;
6. To demonstrate the role of the community college as a lead agency in linking long-term care facilities and mental health services through the mechanism of continuing education.

The contract was renewed for a second year to expand the scope of the demonstration. Training was continued along the plan of the first year and the following new components were added: program activities designed to improve relationships between the community, staff, and residents of long-term care facilities; a program specifically designed for facility administrators and directors of nursing to encourage mental health inservice training on a continuing basis, and provide training designed to ameliorate the potential adverse psychosocial impacts on patients as a result of new Federal regulations which require relocating some patients.

Iowa Lakes Community College conducted the training sessions within the long-term care facilities as much as possible. In instances where there were not sufficient personnel in a particular category or in a particular facility, personnel from several facilities were brought together for a presentation.

A Project Coordinator and four nurse instructors (part time) were employed to instruct and/or coordinate the instruction of the course offerings. These instructors were all experienced in continuing education programs in the health sciences offered by Iowa Lakes Community College, including the practical nurse, nurses aide, and geriatric aide programs. Letters of agreement were obtained from the three mental health facilities (two community mental health centers and a State psychiatric institute) serving the same geographic area, and mental health professional staff members were identified to assist in the teaching. An advisory group was appointed, consisting of representatives of the college; the long-term care facilities in the area; the mental health service agencies; consumers; and a representative from the area Social Service Department. This group assisted in identifying specific objectives, content, training methods, and evaluation design. Orientation and pretraining sessions were conducted for trainer personnel. A system was designed for awarding certificates and academic credit for trainees where feasible.

During the first year of the project the concept of "master" instructors was utilized. Persons with expertise in particular subject areas presented the topic at a nursing home inservice meeting the first part of each month. The R.N. instructors attended these meetings and spent additional time with the "master" instructor preparing to present the same topic at the remaining facilities during that same month.

The second year special workshops were utilized to prepare the R.N. instructors to present various topics. Workshops such as "Death and Dying," Institute on Reality Orientation, Sexual Needs of the Elderly Nursing Home Resident, Staff Motivation, and Rehabilitation by the Sister Kenny Institute were beneficial to the instructors. All the previously mentioned workshops except reality orientation were held within the five-county area and were attended by nursing home staff members and other interested persons.

During the first year of the project 640 nursing home employees enrolled in the inservice education programs. During the fall quarter of 1975, 444 employees attended inservice training programs. Five county/custodial homes joined the inservice project during the second year.

At the outset of the project, two 1-hour meetings per month were conducted in each nursing home. The first meeting was spent presenting the program topic. The second meeting was a "followup" meeting where the topic was further discussed. This format was discontinued after several months because nursing home administrators felt 2 hours per month was in excess of the "adequate amount" of inservice training required. Also, it was a financial burden for those employers who paid hourly wages to their employees to attend inservice training programs; and also, nursing homes found it difficult to schedule a staff meeting with inservice meetings scheduled twice a month.

In place of the followup meeting, the RN instructors visited each nursing home approximately 8 hours per month for discussions with nursing home employees on a one-to-one-basis. These visits enable instructors to establish rapport with the employees and to become more aware of their inservice education needs. These visits have proved to be a valuable part of the program. The RN instructors report that class participation improved as employees became acquainted with the instructor.

During the first year, all departments within the homes attended the same inservice meetings. Dietary and housekeeping departments requested inservice programs specifically for them during the second year.

In the fall of 1974, 4 hours of inservice were offered to dietary personnel. These programs were offered in three locations in the five-county area. With several facilities joining together for these meetings, personnel were able to exchange ideas. The same format was used for housekeeping personnel in the spring of 1975.

During the second project year, a number of the facilities requested inservice programs on physical aspects of care rather than mental health related inservice education programs. Of special interest were the programs concerned with rehabilitation.

Below is a listing of program topics presented in the long-term care facilities.

First year

(1) Attitudes—with yourself, your job, residents, co-workers, relatives, visitors, and community
(2) Mental and physical aspects of the aging process: Biological changes, categorized by body systems
(3) Mental expectations in relation to disease
(4) Depression in the geriatric nursing home resident
(5) Reality orientation
(6) Community resources
(7) Questions and answers: An open program
(8) Death and dying
(9) Communications with brain-damaged residents
(10) Medication (for nursing personnel)

Second year

(1) Reality orientation
(2) Social needs of the elderly nursing home resident
(3) Staff motivation
(4) Rehabilitation (range of motion, body mechanics, bowel and bladder retraining)
(5) Housekeeper's inservice
(6) Dietary inservice
(7) Infection control

County and custodial homes

(1) Communications with brain-damaged residents
(2) Behavior modification
(3) Reality orientation
(4) Seizure control
(5) Attitudes and understanding

One of the participating nursing homes announced plans to close during the second project year, thus providing an opportunity to use the training program to prepare staff to anticipate and deal with problems resulting from relocation of patients. Announcement of closure was made November 20, 1974, and by December 25, 1974, all residents were relocated. There was opportunity for only one inservice program dealing with relocation before the sudden death of the administrator forced an even earlier closing of the facility.

Advisory committee meetings have been poorly attended by those members who had agreed to serve on the committee. Members who live out of the area said it was not feasible to drive a great distance for the meetings, but they would be available for telephone consultation whenever necessary. Nursing home administrators and other interested persons were then invited to attend the meetings.

The program planner for an Area Agency on Aging developed three surveys to determine interaction between the community and the nursing home. (Following are copies of these surveys.) One survey is for the community-at-large. It is anticipated that 100 people chosen at random in each community that has a nursing home will be interviewed. Psychology and sociology students at Iowa Lakes Community College, under the direction of instructors, agreed to do the surveys. The other surveys are for volunteers who work at nursing homes and for families of nursing home residents. A mail survey of 10 percent of the latter groups is anticipated. The surveys will be completed during April 1975. At the March 12, 1975, advisory committee meeting, one nursing home administrator said he doubted if he could cooperate by giving the college the names and addresses of the families of his residents. Other administrators said informational meetings in each community sounded like a good idea, but they doubted that they would want to participate.

The actual training being supported by this demonstration training project contract will terminate at the end of the 1975 academic year and the final project report will be completed soon thereafter. Although a complete report of experiences and recommendations could not be included in this monograph, the Division of Manpower and Training believed an interim report would add significantly to the usefulness of this document. All evidence points to the major role the community college can and does play in the continuing mental health education of all levels of personnel providing services to residents of long-term care facilities.

LONG-TERM CARE FACILITIES

COMMUNITY SURVEY

Surveyor: ______________________ Sex: M F Age _____

Sex of Person Being Interviewed: M F

Approximate Age of Person Being Interviewed: _____

* * * * * * * * * * * * *

1. Do you know about the nursing home in your community? yes no
2. Do you know anyone that works in the nursing home? yes no
3. Do you know any of the residents in the nursing home? yes no
4. Have you ever been a visitor in the nursing home? yes no
5. Have you ever worked in the nursing home? yes no
6. Have you ever helped in the nursing home? yes no
7. Would you be willing to help in the nursing home? yes no
8. Do you think that the nursing home has detracted from the community? yes no
9. Do you think that the nursing home has improved the community? yes no
10. Do you (like dislike or don't know) the employees in the nursing home?
11. Do you (like dislike or don't know) the residents of the nursing home?
12. Would it be better if the nursing home were located in another community? yes no
13. Do you think that the residents are receiving good care? yes no
14. Do you feel that the nursing home and its residents are isolated from the community? yes no
15. Do you have a complaint about the nursing home? yes no
    If yes, what? ____

(Adelphi University)

FUNCTIONS OF THE PROJECT DIRECTOR

1. *Organization and Administration:*
    a. secure qualified instructional staff: Ascertain faculty availability, (it is a fact that the same four trainers are not available for all four of the training programs), develop a pool of faculty; utilize the faculty pool for onsite consultation;
    b. coordinate training sessions to include trainers and lecturers;
    c. prepare bibliography and learning materials;
    d. schedule consultation onsite visits;
    e. coordinate evaluation procedures; distribute evaluation materials.
2. *Publicity—Public Relations:*
    a. prepare brochures; work with designer and printer;
    b. arrange for publicity throughout Nassau and Suffolk Counties in professional journals;
    c. establish personal contacts with personnel in various agencies and organizations;
    d. maintain channels of communication with:
        1. recipients of the project, trainers and evaluators;
        2. other project directors at the bimonthly Adelphi University Continuing Education meetings;
        3. deans of Schools of Nursing and Social Work;
        4. key personnel at training sites.
3. *Faculty Orientation and Consultation:*
    a. plan, coordinate, and implement a training trainers session to develop a cognitive blueprint for evaluation;
    b. discuss and implement philosophy of program and identify trainers' responsibilities;
    c. develop and maintain an ongoing program evaluation with trainers and evaluation consultant;
    d. actualize the training programs:
        1. appropriate involvement in all aspects of ongoing training.
4. *Correspondence, Recordkeeping, and Reports:*
    a. finalize arrangements with various agencies for training sites;
    b. coordinate evaluation data;
    c. arrange for planning and implementing onsite visit;
    d. develop forms for trainee application;
    e. maintain records of all expenses;
    f. initiate faculty contracts;
    g. write progress reports and final summary;
    h. prepare renewal or expansion, or both, of current proposal relevant to evolving needs.

SPECIFIC PROGRAM OBJECTIVES

(Adelphi University)

Specific objectives. Specific program objectives help participants to:

1. Increase their knowledge of the psycho-social-physiological process of aging with emphasis on how the aged experience themselves and their problems.

2. Increase interpersonal competence enabling them to establish and maintain meaningful contact with residents and staff by:

Understanding:

- the way one sends and responds to messages, or both
- different life styles and value systems
- how feelings influence behavior.

Developing skill in:

- listening
- sharing emotional reactions to planned or spontaneous behavior
- practicing communicating one's feelings and ideas in helpful ways.

3. Increase ability to assess physiological, psychological and sociological needs.

4. Become skilled in detecting and preventing the maladaptive patterns of the institutionalized aged.

5. Develop an awareness of the special needs of those residents presenting problems in institutions and provide skilled intervention to maintain optimal functioning.

6. Increase their knowledge and utilization of available internal and external resources.

7. Develop group leadership skills:

- Sensitivity to group process and dynamics.
- Techniques for group leaders.

HOW TO TEACH AND SET UP INSERVICE EDUCATION IN NURSING HOMES

(Massachusetts Mental Health Center)

CURRICULUM OUTLINE

Sessions I—III

I. Introduce questionnaire—describe purpose of evaluation

II. Establish contract around objectives (assumption of administrative support)

III. Procedures for setting up inservice education
  A. Information gathering—styles of approach
    - find out what training now exists and what has been done in the past by informal questioning
    - what kind of things would you like to see in the training program if we set one up?
  B. Formulate tentative plans for inservice program
    1. Who should be trained?
    2. Consideration of time block required (ongoing, weekly, monthly, etc., what part of day, staff depletion, adequate coverage)
    3. Some ideas as to purpose and content
    4. Voluntary or required attendance
    5. Work time or your own
  C. Preliminary planning session with administrator and/or Director of Nursing
    1. Discuss tentative plans
    2. Modify plans

Session IV

IV. Steps in Curriculum Development
  A. Who are the learners?
  B. Their needs and responsibilities
  C. Setting of learning objectives
    1. What do you want learners to know, do, and feel? Differently after training?
    2. Examples from groups (from which objectives are formed during session)

Sessions V-VII

  D. Outlining curriculum in keeping with objectives
    1. What do you want them to know (explore ideas, focus on objectives)?
      a. knowledge of aging process
      b. attitudes
      c. interpersonal skills
      d. Nadler's letter
    2. Focus back on objectives
    3. Finalize curriculum

Sessions VIII-XI

V. How to Teach
  A. What is a good teacher?
  B. Under what circumstances did you have the best learning experience?
  C. What is the relationship between teacher and learner?
  D. Importance of initial climate setting.
  E. Methods—didactic discussion, role playing, audiovisual aids, etc.
  F. Knowledge and awareness of group process.
  G. Importance of continuity.
    1. review at beginning
    2. summary at end

Session XII

Evaluation

Objectives

I. (How to Set Up)
  A. To understand the procedures involved in setting up nursing home in-service education program.
  B. To initiate and get underway an inservice program during the period of the seminar itself.

II. (What to Teach)
  A. To understand steps in curriculum development.
  B. To develop a curriculum for use in their own nursing home inservice program.

III. (How to Teach)
  A. To understand the basic philosophy of this adult educational model.
  B. To understand the teaching methods for the implementation of this model.

GIVING AND RECEIVING HELP
(Adelphi University)

Prepared by Eugene B. Nadler, Ph.D.

Organizational life, and social life in general, requires that people help each other. At some point every person will find himself in the position of *asking for help* from others. At some point every person will find himself in the position of *being asked for help*. We are all very familiar with the *mechanical meaning* of help—it means adding a shoulder to whatever wheel must be turned. This is not the kind of help I want to talk about in this paper.

The kind of help I am talking about is *psychological help*—when you feel boxed in and don't know what to do, or when someone else does. This kind of help is a very complicated thing. With practice and self-awareness, however, most people can come to understand it.

The word "Help" is a little like the word "love"; it has a number of meanings. It may mean one thing to the person asking for help, and another thing to the person being asked.

What *might* the word "help" mean to the person asking for it?

1. When some people say "help me," what they mean is "I want you to tell me what I want to hear." This is the *self-justifying* meaning.

2. When some other people say "help me," what they mean is "I want you to take care of me." This is the *dependency* meaning.

3. When still other people say "help me," what they mean is "I want you to do my job." This is the *manipulative* meaning.

4. And finally, there are still other people who, when they say "help me," mean "I want you to make me see some new possibilities so that I can make up my own mind, and grow as a person." This is the *interdependent* meaning.

What *might* the word ""help" mean to the person being asked for it?

1. When some people get a request for help, they think "Here is an opportunity to get somebody to like me; I will agree with him." This is the *self-serving* meaning.

2. When some other people get a request for help, they think "Here is an opportunity to feel important by having someone else lean on me." This is the *self-inflating* meaning.

3. When still other people get a request for help, they think "Here is an opportunity to use somebody for my own purposes, to get across my pet ideas." This is the *controlling* meaning.

4. And finally, there are still other people who, when they get a request for help, think "Here is an opportunity to make someone think deeply about some new possibilities, allow him to make up his own mind, and make him grow on his own into a better person." This is the *mature* meaning.

I would like to suggest that the only request for help that qualifies as "real" is the interdependent request, and the only offer of help that is "real" is the mature offer.

Deep down, most people know this. Deep down, most people want real helping relationships, even when *on the surface* they seem to be asking only for agreement, only for mothering, only for manipulation of the helper, or even when on the surface they only offer agreement, or mothering, or control of the person asking for help. It is very rare, however, to find someone who wishes to be helped in the real sense. And it is equally rare to find someone who can really be of help. As a result, we frequently avoid asking for help, and we frequently avoid trying to give it.

Why are we afraid to ask for help?

1. We are afraid to admit to ourselves that we have problems.

2. We are afraid the other person will only agree with us, instead of clarifying our misconceptions. (We are also afraid others will disagree.)

3. We are afraid the other person will make us feel like children, instead of helping us to become more adult.

4. We are afraid the other person will use us for his own purposes.

I would like to suggest a new way of looking at this problem of asking for help. I would like to suggest that it takes a *strong person* to ask for real help—a person who can admit to himself that he has problems, a person who can take both agreement and disagreement, a person who is not afraid to feel like a child for a short space of time, and a person who has enough confidence in himself that he is not afraid of being used.

Why are we afraid to give help?

1. We are afraid of hearing about another person's problems because this reminds us that we have problems too that we may be afraid to face.

2. We have been trapped before into giving advice, not having it accepted, exerting pressure to get it accepted, thus turning the whole thing into an argument, and maybe losing a friend in the process.

3. We have been trapped into making other people lean on us, only to find out later that we got more than we bargained for, that we just didn't want that kind of responsibility.

4. We have been trapped before into giving help for our own purposes, only to have the other person eventually rebel, and become "ungrateful."

I would like to suggest that it takes a *strong person* to really be helpful—a person who is not afraid of facing up to problems, in himself or in others, a person who can resist being trapped by his own needs to be liked, to feel important, or to control others, a person who can resist being trapped by the needs of others for agreement, or mothering, or the need to be dominated by a powerful friend or leader.

Beyond this, I offer the following formal suggestions when you are in a situation of trying to be of help to other people:

1. Be a good listener.
2. Try to see things through the other person's eyes.
3. Be sensitive to his feelings. His problem is scaring him enough; don't add to it.
4. Avoid judgments and evaluations, like "that's good" and "that's bad."
5. Don't give advice. Rather, try to make him *think*, by asking questions about other possibilities.

Adelphi University

TABLE 1. PROCESS AND CONCEPT OF LEARNING

By Hildegarde E. Peplau, Ed.D. *Some Clinical Approaches to Psychiatric Nursing*, Burd and Marshall, eds. New York: Macmillan, 1963.

Learning is an active process which utilizes the thinking and perceiving abilities and knowledge previously acquired for three major purposes: (1) acquiring new knowledge to explain events, (2) facilitating change, and (3) solving problems.

Steps in learning as a concept and as a process	Operations, performances, behaviors, separate skills, associated with each step in learning (Major use of the perceptual processes—see, hear, smell, touch, etc.)	Examples of statements by the nurse to facilitate development of each step in a patient, in the total sequence of the process of learning
1. To observe: The ability to notice what went on or what goes on now.	To see with one's eyes To hear To feel using empathic observation To feel using tactile senses	What do you see? What is that noise? Are you uncomfortable? Do you have something to say to me? Could I share the thought with you or is it private? Tell me about yourself. What happened? I don't follow. Tell me, what did you notice? You noticed what? Did you see this happen? Who was with you? When did this occur? What is the color? Where were you? Tell me. Then what? Go on. Give me a blow-by-blow description. Tell me every detail from the beginning.
Assumption: The patient can describe the situation as he or she viewed it with encouragement and assistance from a person who can focus exclusively on the situation of the patient.		
2. To describe:	Increased verbalization	Tell me about the feeling.

(Continued)

TABLE 1. PROCESS AND CONCEPT OF LEARNING—Con.

<table>
<tr><th>Learning</th><th>Operations</th><th>Nurse Statements
Who, What, When, Which, Where</th></tr>
<tr><td>The ability to recall and tell the details and circumstances of a particular event or experience.</td><td>Greater recall
Enumeration of details
Focus on details of one event
Observe patient's general ambiguous terms for person(s) and nurse's question words assisting patient to be specific.
<table>
<tr><th>Patient's terms</th><th>Nurse's Question Words</th></tr>
<tr><td>1. Everybody
They
Them
Technicians</td><td>Who?</td></tr>
<tr><td>2. The nurses
The doctors</td><td>Which?</td></tr>
<tr><td>3. The ones who work from 8–4 (narrowing)</td><td>What are their names?</td></tr>
<tr><td>4. Miss Jones (specific name)</td><td></td></tr>
</table></td><td>What name would you give to your feeling?
Tell me more.
Then what?
Go on,
Give me an example.
Who are they?
What about that?
For instance?
Describe that further.
Give me a blow-by-blow account of that.
What did you feel at the time?
What happened just before?
Which was it?
Who was the person?
What did you say?
What did your comment evoke in the other?</td></tr>
<tr><td>3. To analyze:
The ability to review and to work over the raw data with another person.

Step 3 may occur simultaneously with Step 4.</td><td>Examples of the kinds of analysis used by the nurse.
Identify needs
Decode key symbols
Distinguish literal and figurative
Sort and classify
1. Impressions
2. Speculations
3. Thematic abstractions
4. Hypotheses
5. Generalizing
Compare
Summarize
Sequence
Application of concepts
Application of personality theory as a frame of reference
Formulating relations resulting from the foregoing:
1. Cause and effect
2. Temporal
3. Thematic
4. Spatial</td><td>Use nurse statements of observation step, as well.
Explain.
Help me to understand that!
What do you see as the reason?
What was the significance of that event?
What are the common elements in these two situations?
What is the connection?
Boil this down to the one important aspect.
What caused this?
What was your part in it?
In what way did you participate?
In what way did you reach this decision?
What caused this feeling?
(I expected you at 8:30; you were late; that caused my anger.)
Have you had this feeling before?
Is there anything similar in this situation to your previous experience?</td></tr>
</table>

(*Continued*)

TABLE 1. PROCESS AND CONCEPT OF LEARNING—Con.

Learning	Operations	Nurse Statements Who, What, When, Which, Where
4. To formulate: The ability to give form and structure, to restate in a clear, direct way the connections resulting from Step 2 (analysis).	Restatement of data in light of Step 3 Verbal or written result of analysis of data	State the essence of this situation in a sentence or so. What did you feel? What did you think? What did you do? Tell it to me in a sentence or so. Tell me again. Was there a discrepancy between what you felt, thought, and did? What would you say was the problem? What name would you give to the patterns of your behavior as you interacted with another person?
5. To validate (by consensus): The ability to check with another person and to reach agreement as to the result of Step 4 (Formulation), or to state clearly the issue if there is divergence in the formulations of the two persons.	Checking with, comparing notes of two or more people Pt.: Are you anxious? (Pt. trying to validate.) N.: (is anxious.) No, I'm not. Yes, I could say I am. What called my anxiety to your attention?	Is this what you mean? Let me restate. Is this what you were saying? Do you go along with this? Is this what you believe? It seems that—Is this the way it appears to you? Is it that you feel angry when people tell you what to do? Am I correct in concluding that—? Are you saying—?
6. To test: The ability to try out the result of Step 4 (formulation) in situations with people, things, etc., for utility, completeness.		(Set up situations where patient can try out new behavior patterns.) Now that you have thought about this and come to this conclusion, why don't you try it out? What would you do if a situation like this came up again? In what way can you use this conclusion to prevent repeating this mistake? In what way will this conclusion help you in the future? What difference will it make now that you know this?
7. To integrate: The ability to see the new in relation to or	Enmeshing the new with the old	

(Continued)

Is there a struggle for leadership? What effect does it have on other group members?

III *Styles of Influence.* Influence can take many forms. It can be positive or negative; it can enlist the support or cooperation of others or alienate them. *How* a person attempts to influence another may be the crucial factor determining how open or closed the other will be toward being influenced. Items 10 through 13 are suggestive of four styles that frequently emerge in groups.

10. Autocratic: Does anyone attempt to impose his will or values on other group members or try to push them to support his decisions? Who evaluates or passes judgment on other group members? Do any members block action when it is not moving the direction they desire? Who pushes to "get the group organized?"
11. Peacemaker: Who eagerly supports other group members' decisions? Does anyone consistently try to avoid conflict or unpleasant feelings from being expressed by pouring oil on the troubled waters? Is any member typically differential toward other group members—gives them power? Do any members appear to avoid giving negative feedback, i.e., who will level only when they have positive feedback to give?
12. Laissez faire: Are any group members getting attention by their apparent lack of involvement in the group? Does any group member go along with group decisions without seeming to commit himself one way or the other? Who seems to be withdrawn and uninvolved; who does not initiate activity, participates mechanically and only in response to another member's questions?
13. Democratic: Does anyone try to include everyone in a group decision or discussion? Who expresses his feelings and opinions openly and directly without evaluating or judging others? Who appears to be open to feedback and criticisms from others? When feelings run high and tension mounts, which members attempt to deal with the conflict in a problem-solving way?

IV *Decision-Making Procedures.* Many kinds of decisions are made in groups without considering the effects of these decisions on other members. Some people try to impose their own decisions on the group, while others want all members to participate or share in the decisions that are made.

14. Does anyone make a decision and carry it out without checking with other group members (self-authorized)? For example, he decides on the topic to be discussed and immediately begins to talk about it. What effect does this have on other group members?
15. Does the group drift from topic to topic? Who topic-jumps? Do you see any reason for this in the group's interactions?
16. Who supports other members' suggestions or decisions? Does this support result in the two members deciding the topic or activity for the group (handclasp)? How does this affect other group members?
17. Is there any evidence of a majority pushing a decision through over other members' objections? Do they call for a vote (majority support)?
18. Is there any attempt to get all members participating in a decision (consensus)? What effect does this seem to have on the group?
19. Does anyone make any contributions which do not receive any kinds of response or recognition (plop)? What effect does this have on the members?

V *Task Functions.* These functions illustrate behaviors that are concerned with getting the job done, or accomplishing the task that the group has before them.

20. Does anyone ask for or make suggestions as to the best way to proceed or to tackle a problem?
21. Does anyone attempt to summarize what has been covered or what has been going on in the group?
22. Is there any giving or asking for facts, ideas, opinions, feelings, feedback, or searching for alternatives?

23. Who keeps the group on target? Who prevents topic-jumping or going off on tangents?

VI *Maintenance Functions.* These functions are important to the morale of the group. They maintain good and harmonious working relationships among the members and create a group atmosphere which enables each member to contribute maximally. They insure smooth and effective teamwork within the group.

24. Who helps others get into the discussion (gate openers)?
25. Who cuts off others or interrupts them (gate closers)?
26. How well are members getting their ideas across? Are some members preoccupied and not listening? Are there any attempts by group members to help others clarify their ideas?
27. How are ideas rejected? How do members react when their ideas are not accepted? Do members attempt to support others when they reject their ideas?

VII *Group Atmosphere.* Something about the way a group works creates an atmosphere which in turn is revealed in a general impression. In addition, people may differ in the kind of atmosphere they like in a group. Insight can be gained into the atmosphere characteristic of a group by finding words which describe the general impressions held by group workers.

28. Who seems to prefer a friendly congenial atmosphere? Is there any attempt to suppress conflict or unpleasant feelings?
29. Who seems to prefer an atmosphere of conflict and disagreement? Do any members provoke or annoy others?
30. Do people seem involved and interested? Is the atmosphere one of work, play, satisfaction, taking flight, sluggishness, etc?

VIII *Membership.* A major concern for group members is the degree of acceptance or inclusion in the group. Different patterns of interaction may develop in the group which give clues to the degree and kind of membership.

31. Is there any subgrouping? Sometimes two or three members may consistently agree and support each other or consistently disagree and oppose one another.
32. Do some people seem to be "outside" the group? Do some members seem to be "in?" How are those "outside" treated?
33. Do some members move in and out of the group, e.g., lean forward or backward in their chairs or move their chairs in and out? Under what conditions do they come in or move out?

IX *Feelings.* During any group discussion, feelings are frequently generated by the interactions between members. These feelings, however, are seldom talked about. Observers may have to make guesses based on tone of voice, facial expressions, gestures, and many other forms of nonverbal cues.

34. What signs of feelings do you observe in group members: anger, irritation, frustration, warmth, affection, excitement, boredom, defensiveness, competitiveness, etc?
35. Do you see any attempts by group members to block the expression of feelings, particularly negative feelings? How is this done? Does anyone do this consistently?

X *Norms.* Standards or ground rules may develop in a group that control the behavior of its members. Norms usually express the beliefs or desires of the majority of the group members as to what behaviors *should or should not* take place in the group. These norms may be clear to all members (explicit), known or sensed by only a few (implicit), or operating completely below the level of awareness of any group members. Some norms facilitate group progress and some hinder it.

36. Are certain areas avoided in the group (e.g., sex, religion, talk about present feelings in group, discussing the leader's behavior, etc.)? Who seems to reinforce this avoidance? How do they do it?
37. Are group members overly nice or polite to each other? Are only positive feelings expressed? Do members agree with each other too readily? What happens when members disagree?

38. Do you see norms operating about participation or the kinds of questions that are allowed, e.g., "If I talk, you must talk"; "If I tell my problems you have to tell your problems." Do members feel free to probe each other about their feelings? Do questions tend to be restricted to intellectual topics or events outside of the group?

ROLE PLAY OF A BEGINNING GROUP IN A NURSING HOME

(Adelphi University)

Goal: To help trainees think about how groups begin, roles people play in groups and the role of the group leader.

Time Required: One hour.

Process: Roles are passed out at random to 9 people. The number may be changed by having more than 1 of certain roles. Two facilitator roles are assigned.

If the class is large the group is divided, with an inner circle being the role play and the outer circle observing. Observers are asked to observe particular participants as well as the total group interaction.

The role play is done twice, with process discussion after each experience. The outer circle becomes the participants the second time. Fifteen minutes should be allowed for the role play and about the same amount of time for process discussion.

Participants do not read their assigned role to the group until after the role play has been completed. They are instructed to play their role any way they feel comfortable and not to be afraid to have fun with it.

Questions for Discussion

1. Did the group interaction seem real?
2. Do you think we see these various types of people in groups?
3. Was the facilitator helpful to the group process?
4. What are the advantages and disadvantages of co-leaders?
5. What ideas does this give you in thinking about how you might begin your own group?

ROLES

This is the first meeting of a patient group whose purpose is to organize a current events discussion group. You are a staff member who has helped to bring the group together. There is one other staff member working with you.

This is the first meeting of a patient group whose purpose is to organize a current events discussion group. You are a staff member who has a sensitivity to the *social-emotional* tone of the meeting. You try to keep things going smoothly and to mediate all possible disagreements and problems.

This is the first meeting of a patient group whose purpose is to organize a current events discussion group. You are a member who is *afraid of new ideas* and fights strongly against them. You generally react with criticism, disagreement or hostility.

This is the first meeting of a patient group whose goal is to organize a current events discussion group. You tend to be a very withdrawn person, who shows his hostility in quietly subtle ways.

This is the first meeting of a patient group whose purpose is to organize a current events discussion group. You are a *task-oriented* member, anxious to keep the group working on its goals and not to be sidetracked.

This is the first meeting of a patient group whose purpose is to organize a current events discussion group. You are a pretty *self-centered* member and tend to put personal goals above group goals.

This is the first meeting of a patient group whose purpose is to organize a current events discussion group. You are a very *dependent* member who tends to look to others for support and advice. You may tend to make irrelevant remarks.

This is the first meeting of a patient group whose purpose is to organize a current events discussion group. You tend to be quite opinionated and aggressive about your ideas.

FAMILY ROLE PLAY: PREADMISSION CRISIS

(Adelphi University)

By Joan Fiorello, M.S., R.N.

Situation

This is a meeting that takes place between staff members, a patient, Mrs. Nathanson, and members of Mrs. Nathanson's family, regarding her admission to a small, private nursing home.

MRS. NATHANSON

You are a 75 year old widowed Jewish woman who had a stroke 6 months ago. You cannot speak but understand what is happening around you. You regret the fact that you and your husband cut off all ties with your elder son when he married a girl from a Catholic family 20 years ago but you do not know how to express it after all this time.

NURSE

You are a nurse employed by a small private nursing home. You and a social worker come to the home of a 74 year old widowed woman who had a stroke 6 months ago. You and the social worker have come to decide whether Mrs. Nathanson should be admitted to the institution for which you work and to help make the financial arrangements.

39 YEAR OLD SON

You are a 39 year old man whose 75 year old widowed mother suffered a stroke 6 months ago. You and your younger sister have decided she must be placed in a nursing home and receive the best of care. You and your sister have paid for around-the-clock help to keep your mother at home for several months. You are embarrassed about approaching your 41 year old successful rich brother about helping with the cost since you have not spoken to him in 20 years.

41 YEAR OLD SON

You are a 41 year old successful businessman. Twenty years ago you were put out of the family circle when you married a girl from an Irish Catholic family. Your Jewish parents were very upset and said they never wanted to see you again. Over the years you have written to your parents but have always received letters back unopened. You feel sad and bitter about this.

Your father died several years ago and your mother had a stroke 6 months ago. Your brother and sister have recently called to tell you this news because mother will have to be placed in a nursing home. They do not want to accept "charity" in the form of Medicare or welfare payments but cannot afford to pay the costs without your help.

SOCIAL WORKER

You are a social worker employed by a small private nursing home. You and a nurse have come to the home of a 75 year old widowed woman who had a stroke 6 months ago. You and the nurse have come to the home to decide whether Mrs. Nathanson should be admitted to the institution for which you work and to help them make the financial arrangements.

37-YEAR OLD DAUGHTER

You are a 37 year old woman with five small children whose widowed mother had a stroke 6 months ago. You and your older brother have decided she must be placed in a nursing home. You and your brother have asked an older rich brother to help with the cost. You feel your parents were right to throw him out of the family twenty years ago when he married a Catholic girl against the wishes of your Jewish parents. Your approach to him is therefore that this is a purely business arrangement and does not mean you like him or want him back in the family again.

37-YEAR OLD DAUGHTER-IN-LAW

You are the 37 year old wife of a successful businessman. Twenty years ago you married a man from a Jewish family against the wishes of your Catholic parents. His parents have never communicated with you since your marriage. Your own parents have accepted their son-in-law to a certain extent but relations are strained. Recently you have been thinking of separating from your husband because of sexual and other problems. Now that your three teenage children are close to grown up you would like to make a new life for yourself. But you are not quite ready to leave and feel you must help your husband through this episode. His brother and sister have recently approached him about helping to pay the cost of private nursing home care for their widowed invalid mother.

ROLE PLAY: CHANGE

(Adelphi University)

By Joan Fiorello, M.S., R.N.

SITUATION

Recently several incidents have occurred on this geriatric unit. Yesterday a man who has been a resident here for a few months threw his breakfast tray at the physician and said he was not going to eat any more of this cold, tasteless food.

A woman resident who has been here for a year has become very quiet and refuses to eat. Last night a newly admitted man was found trying to hang himself from the shower rod with his belt.

You are a 35 year old female social worker. When you came to work at this institution 2 years ago you thought you would be able to run groups and develop relationships with patients. You are kept so busy by paper work and routine interviews with family members that you have not been able to do this. You'd like to see some changes but are not sure the nurse or the nurse assistants can run groups.

You are a twenty-two year old woman who works as a nurse assistant on this unit. You went to college for 2 years but left when you felt what you were learning was not relevant to what was happening in the world. You have worked as a salesgirl, office clerk and for one year, at the position you now hold. You like working with people and are thinking about returning to school to learn how to do a better job at it. You have recently attended an eight-week group process course at a local university and would like to start a group on this unit. The efforts of the staff nurse who went to the course with you have been met with resistance. You are thinking about how to proceed.

You are the head nurse on this 30 bed unit. You are a 32 year old divorcee. You have some ideas about making this a more interesting environment for patients and staff. You really need this job because you are the sole support of 3 small children. The supervisor and administrator have been very helpful to you in working out a flexible schedule that allows you to spend maximum time with your children.

You are a 60 year old male physician. You came to work at this institution 2 years ago because you thought it would be an easier job than your full time private practice. You are planning to retire and move to Florida at the end of next year and want things to continue without any big problems until then. You believe the elderly people in your care should be treated kindly and taken care of until they die. They have worked hard and should be allowed to take it easy for the rest of their lives without any responsibilities.

Several of your friends have died recently. You had a mild heart attack 5 years ago and are trying to live quietly. You are afraid of dying in pain and dying before you can enjoy your retirement but you are ashamed of these feelings and don't want to talk about them.

You are the administrator of this institution. You are a 50 year old man. You have been invited to this team meeting by the head nurse. You would like to do what's best for patients and staff but have some conflicting feelings about the risks involved in allowing the residents more responsibility for their own care.

You are a 75 year old man who has been a resident of this unit for 2 years since you had a stroke. You can get around in a wheelchair. You have been elected to represent the residents at this unit meeting. You ran your own haberdashery business for 30 years before retiring 15 years ago and were active in community groups.

You are the staff nurse on this unit. You are a 45 year old woman who returned to work three years ago after being away from work and raising a family for 15 years. Now that your children are older you would like to do something interesting and rewarding yourself. You like working here but think you and other staff should spend more time with patients. Recently you and a nurse assistant from this unit have taken a course in group process. You would like to start a group with patients on this ward. You have made a few attempts but other staff members have been discouraging and you aren't sure of what to do next. Maybe this meeting is a good opportunity to try again.

You are a 29 year old woman who is the dietician for this unit. You are not too sure why you were invited to this meeting but are interested in the patients and try to listen to their complaints and requests with an open mind. You have the vague feeling that often the complaints about food are not what the real problem is but don't know what to do about it.

You are a 45 year old male psychologist. You have a large private practice. You work for this institution four hours a week. You are not really interested in working with elderly people, they remind you of your aging parents and your problems with them. You are ambitious and believe that having this job listed on your resume will help your career with all the recent interest in the aging person. Sometimes you function as mediator in the team when differing points of view are expressed.
